SIGN Eating Disorders Consultation

COMMENTS RECEIVED FROM EXTERNAL REFEREES AND OTHERS

All reviewers submitted declarations of interests which were viewed prior to the addressing of comments.

Invited reviewers			**Type of response and declared interests**
AG	Dr Andrew Gallagher	Consultant Physician & Endocrinologist, Honorary Clinical Associate Professor, Queen Elizabeth University Hospital, Glasgow	*Individual response.* Nothing declared.
AH	Alison Hall	Advanced Autism Practitioner, NHS Forth Valley	*Individual response.* Nothing declared.
AJ	Agnes Louise Johnston	Consultant Psychiatrist, Eden Unit, Royal Cornhill Hospital, Aberdeen	*Individual response.* *Non-financial personal interests eg research projects* - I have a limited research interest in mentalisation based therapy, and have participated in research around this topic, although unpublished.
AMc	Ms Andrea McCartney	Dietetic Advanced Clinical Specialist in Eating Disorders, Tertiary Eating Disorder Specialist Service	*Individual response.* Nothing declared.
CV	Dr Catherine Varnell	Consultant Clinical Psychologist, CAMHS	*Individual response.* Nothing declared.
DC	Dr Donna Corrigan	Consultant Paediatrician, University Hospital Wishaw	*Individual response.* *Any other relevance which could be perceived to affect your partiality* - My daughter has suffered from an eating disorder and was treated between ages of 13-18 years. My experiences as a carer will influence my responses.
DS	Mrs Debbie Smith	Specialist Occupational Therapist, Regional Eating Disorders Unit, Livingston	*Individual response.*

			Nothing declared.
EB	Emma Broadhurst	National Officer Scotland, BEAT	*Group response.* *Nature and purpose of your group or organisation* - Voluntary org providing support to those with lived experience, carers, friends and family. *How might the statements and recommendations in the draft SIGN guideline impact on your organisation's functions/status/productivity?* - Our organisation would be strengthened following the SIGN recommendations as we support those with lived experience, their families and friends to ensure they all receive the highest standard of care. Implementation of these guidelines will support this and our campaign to guarantee this for all people with experience of eating disorders across Scotland. Through following and implementing the guidelines Beat can provide the care and support for individuals and their carers/ families/ friends to allow the NHS to focus on treatment.
GA	Dr Gail Allsopp	Clinical Policy Lead, The Royal College of General Practitioners	*Group response.* *Nature and purpose of your group or organisation* - Royal College with 54,000 GP members *How might the statements and recommendations in the draft SIGN guideline impact on your organisation's functions/status/productivity?* - National guidelines will directly affect the way our members review, investigate and treat our patients.
HB	Dr Heike Bartel	Associate Professor of German, Department of Modern Languages and Cultures, The University of Nottingham	*Individual response.* *Non-financial personal interests for the last 12 months, eg grants* - I received one Wellcome grant (Prime

			Funding via UoNottingham) and one AHRC follow-on funding grant for projects on communicating personal experiences of eating disorders in men to healthcare professionals in the last 12 months. *Non-financial personal interests eg research projects* - Involvement as CoI and PI in research projects on eating disorders in a cultural/ arts & humanities context, eg, patient-centred 'stories' on EDs in men and boys to train healthcare professionals.
JMc	Jennifer McNeill	Person with lived experience or caring experience	*Individual response.* Nothing declared.
KBr	Ms Kate Brown	Physiotherapy Lead (Mental Health), Cambridge and Peterborough NHS Foundation Trust	*Individual response.* Nothing declared.
KJ	Ms Karen Joash	Consultant in Obstetrics and Gynaecology, Imperial College, London	*Individual response.* Nothing declared.
KL	Dr Katharine Logan	Consultant Psychiatrist in Psychotherapy, Rivers Centre	*Individual response.* Nothing declared.
LS	Ms Lorraine Small	Community Psychiatric Nurse, CAMHS Lothian	*Individual response.* Nothing declared.
MMac	Ms Michelle MacDonald	Dietitian, NHS Fife	*Individual response.* Nothing declared.
PC	Dr Philip Crockett	Consultant Psychiatrist in Eating Disorders/Psychotherapy, EDS Royal Cornhill Hospital, Aberdeen	*Individual response.* *Non-financial personal interests eg research projects* - I

			have co-written and helped research a variety of papers on topics connected to treatment of EDs, I have written book chapters on the same. I gained no financial benefits from the above.
RN	Dr M Radzi M Noh	Consultant Physician, St John's Hospital, Livingston	*Individual response.* *Any other relevance which could be perceived to affect your partiality* - I am a physician with job plan time in REDU NHS Lothian, but also a diabetes and endocrinology physician with links in Lothian.
RT	Dr Richard Taylor	Consultant Psychiatrist in Medical Psychotherapy, Regional Eating Disorders Ward	*Individual response.* Nothing declared.
SB	Dr Subhayu Bandyopadhyay	Consultant Obstetrician, Aberdeen Maternity Hospital, Aberdeen	*Individual response.* Nothing declared.
SG	Sara Gemmell	Person with lived experience or caring experience	*Individual response.* Nothing declared.
SGF	Dr Shridevi Gopi-Firth	Specialty Doctor in Eating Disorders, NHS Forth Valley	*Individual response.* *Any other relevance which could be perceived to affect your partiality* - I am a BAME person volunteering with Third sector organisations to improve access and health equity for BAME and other minority populations; my ethnicity may be perceived by some as affecting my sense of partiality when assessing needs of minorities.
SMcC	Ms Shona McCann	Specialist Midwife in Perinatal Mental Health, Maternity Lead, Perinatal Mental Health Managed Clinical Network, Aberdeen Maternity Hospital, Aberdeen	*Individual response.* Nothing declared.
WW	Dr Wojtek Wojcik	Consultant Psychiatrist, Royal Infirmary of Edinburgh	*Individual response.*

			Any other relevance which could be perceived to affect your partiality - Clinical work with patients with eating disorders.
Open consultation			**Type of response and declared interests**
AGe	Aaron George	Physiotherapy Team Lead, Mental Health Services, Stobhill Hospital, Glasgow	*Individual response.* Nothing declared.
AL	Mr Andrew Langford	Chief Executive, British Association for Music Therapy	*Group response.* *Nature and purpose of your group or organisation* - Professional organisation representing Music Therapists. *How might the statements and recommendations in the draft SIGN guideline impact on your organisation's functions/status/productivity?* - These guidelines would leave out the potential for extremely important input from the Creative Therapies - Music, Art and Drama - for a vast majority of people who this guidance is for.
AR	Andrew Robinson	Consultant Psychiatrist, Royal Cornhill Hospital, Aberdeen	*Individual response.* Nothing declared.
AT	Alison Thomson	Executive Director-nursing, Mental Welfare Commission for Scotland	*Group response.*
BC	Brid Corrigan	Specialist Speech and Langauge Therapist, Tier 4 CAMHS	*Individual response.* Nothing declared.
DW	Diane Waugh	Development Manager, SupportED Scotland	*Group response.* *Nature and purpose of your group or organisation* - Voluntary Organisation providing support to people over 18 affected by Eating Disorders.

			How might the statements and recommendations in the draft SIGN guideline impact on your organisation's functions/status/productivity? - The statements and recommendations will have a positive impact on our service user experience which will strengthen their recovery process and increase their confidence to seek more informal emotional support through our peer support groups and telephone befriending. This will improve our development of new services and service user engagement.
EL	Elaine Lockhart	Consultant in Paediatric Liaison Psychiatry, Royal Hospital for Children, Glasgow	*Individual response.* Nothing declared.
EM	Eva Musby	Person with lived experience or caring experience	*Individual response.* Nothing declared.
FH	Fenella Hodgson	Art Therapist, Royal Edinburgh Hospital	*Individual response.* Nothing declared.
FB	Fiona Bromelow	Person with lived experience or caring experience	*Individual response.* Nothing declared.
GV	Gail Vaux	Person with lived experience or caring experience	*Individual response.* Nothing declared.
HD	Harriet Davis	Person with lived experience or caring experience	*Individual response.* Nothing declared.
HC	Heather Cassie	Chairperson, North East Eating Disorders Support(Scotland)	*Group response.* *Nature and purpose of your group or organisation* - Self help group for adults challenged by any eating disorder

			and their carers. *How might the statements and recommendations in the draft SIGN guideline impact on your organisation's functions/status/productivity?* - Our group members consist of those personally challenged by eating disorders and their carers. Some may not have accessed any professional help, may be on waiting list, may be in treatment or finished treatment, therefore recommendations will directly affect them all in one way or another.
JW	Dr James Ward	Medical Director, Scottish Ambulance Service	*Group response* – special health board. Nothing declared.
KB	Kevin Brown	Consultant Psychiatrist, RHSCYP (Edinburgh CAMHS IPU)	*Individual response.* Nothing declared.
MC	Mandy Christie	Person with lived experience or caring experience	*Individual response.* Nothing declared.
MS	Melanie Stevenson	Person with lived experience or caring experience	*Individual response.* Nothing declared.
NHS24		NHS 24	*Group response.* Nothing declared.
RS	Dr Ross Shearer	Consultant Clinical Psychologist, NHS Glasgow & Clyde Specialist Weight Management Service, Glasgow	*Individual response.* Nothing declared.
RCPL		Royal College of Physicians, London	*Group response.* Nothing declared.

SY	Shirelle Young	Art Psychotherapist, Eden Unit, Royal Cornhill Hospital, Aberdeen	*Individual response.* Nothing declared.
VL	Vicki Lindsay	Person with lived experience or caring experience	*Individual response.* Nothing declared.

Section	Comments received		Development group response
	JW	While unable to comment on the detailed clinical care interventions proposed, SAS welcomes all efforts to support patients, families and carers and avoid crisis scenarios.	Thank you. No action required.
	AJ	The guideline is, in my opinion, clear and comprehensive. Thank you.	Thank you. No action required.
	EM	Thank you all for this major piece of work, which you carried out when many of you were surely snowed under with the huge demand for treatment. Thank you also for including the general public not just in written documents, but in a Teams online meeting.	Thank you. No action required.
	MMac	Addressing ED and autism within the guide as with ED and PD would be helpful given increasing evidence of co morbidity and the challenges ASD presents for patients with ED trying to access services. Does there also need to be some recommendations about the interface between inpatient and community services? Recommendations around medical monitoring would also be helpful. Guideline mentions ECG but nil guidance re frequency DEXAs etc	ED and ASD as a comorbidity was included in the evidence review but no robust studies have been found. Reference to expert advice, the PEACE Pathway, has been added to sections 1.2.1 and 16.2 This has been added to section 3.5. No evidence was identified for or against the use or frequency of DEXA. A sentence has been added to section 12 to explain this.
	KB	The guideline is obviously written by experienced clinicians with familiarity with the daily challenges of working in this field. I think this lends a lot of credibility to the guideline.	Thank you. No action required.
	VL	Pleased to note that the importance of Early Intervention, carer support and a holistic approach are recognised.	Thank you. No action required.
	FH	Please include Art Therapy in your SIGN guideline.	In response to the comments on arts therapies throughout the guideline, SIGN conducted a search for studies on art therapies and eating disorders. The search identified one systematic review on music therapy, which concluded that

			music may be beneficial, but studies were heterogeneic and there was a lack of RCTs: *Testa, F et al. A systematic review of scientific studies on the effects of music in people with or at risk for eating disorders Psychiatria Danubina, 2020; Vol. 32, No. 3-4, pp 334-345* SIGN also contacted Shirelle Young who supplied the following references from the British Assoc of Art Therapists: *Mirabella G. Is art therapy a reliable tool for rehabilitating people suffering from brain/mental diseases? J Altern Complement Med. 2015 Apr;21(4):196-9* - this is a report, not research and does not cover eating disorders specifically. *Holmqvist, G., Lundqvist-Persson, C. (2012)* *Is there evidence for the use of art therapy in treatment of psychosomatic disorders,* *eating disorders and crisis?: A comparative study of two different systems for evaluation. Scandinavian Journal of Psychology, 53(1): 47-53* - this does not answer the question on efficacy of an art therapy intervention. *Lucy Shaw (2020) 'Don't look!' An online art therapy group for adolescents with Anorexia Nervosa, International Journal of Art Therapy, 25:4, 211-217* - this is a description of how a course is conducted, rather than a study on efficacy of treatment. *Bucharová M, Malá A, Kantor J, Svobodová Z. Arts Therapies Interventions and Their Outcomes in the Treatment of Eating Disorders: Scoping Review Protocol. Behav Sci (Basel). 2020;10(12):188.* - This is a review protocol only. Hopefully the full review will be available when it is time to update the guideline. *Eileen Misluk-Gervase (2021) Art Therapy and the Malnourished Brain: The Development of the Nourishment*

			Framework, Art Therapy, 38:2, 87-97 - This is an opinion pience and case study. There is therefore no robust evidence to include in the guideline. A sentence has been added to the introduction to state that other therapies are available and have a role in the management of patients and that the guideline has focused on areas where there is some published evidence. A call for research has been added to section 18.2.
	MS	I think the reviews of the research are excellent and how conclusions about treatment and intervention recommendations have been reached. I think, though, that the actual recommendations need to be highlighted - maybe in bold - so that any clinician wishing to access knowledge on how to proceed/offer care/intervene can find that information quickly. This is a huge document to work through when maybe the actual guidelines themselves need to be clearly immediately accessible and visible.	Thank you. A separate quick reference guide which summarises the recommendations will be published along with the guideline.
	AH	Further suggestions for clinicians to give extra consideration to Autistic adults and children should be given. Education for all working in Eating disorder services about Autism and specifically, sensory sensitivity and how it impacts on function.	ED and ASD as a comorbidity was included in the evidence review but no robust studies have been found. Reference to expert advice, the PEACE Pathway, has been added to sections 1.2.1 and 16.2.
	HC	This guideline needs to be regularly reviewed and updated or renewed. Many thanks to all those dedicated professionals who have contributed their time, expertise and energy to its development.	The guideline will be reviewed for update three years after publication.
	CV	Prevention of ED guideline as part of this guideline or a separate guideline? states "There is a need for the agreement of standardised outcome measures and the implementation of an associated national data set across all eating disorder services" ?is it within the scope of this guideline to also suggest valid, researched outcome measures it would suggest the use of in ED work/by ED services?	Prevention of ED would need to be a separate guideline. Standardised outcome measures should be agreed nationally. The guideline group feel this is would be the remit of the Implementation Group being convened by the Scottish Government as a result of the Review of Eating disorders Services, published in June 2021.

		highlighting more the need for more adolescent ED research of good quality or just more full stop and future research needs surrounding ED and ASD/NDD.	There is a need for more research in all patient groups, and this is highlighted in section 18.2
	HB	The necessity to produce these guidelines is made very clear at the end. Starting with them would add depth, urgency and momentum. There are clearly different writing styles and some variants in approaches. A prominent example are the more formulaic R for AN, BN and BED in adults, all adopting a repetitive formula (that perhaps could take differences more into account), that stand in contrast to a different writing style and presentation of evidence in the sections and R on pregnancy and ED. Whilst some variations in writing style are perhaps unavoidable, care may be needed to level underlying approaches and methods. I personally would like to see more of the ones applied regarding ED and pregnancy: verbatim quotations, avoidance of formula etc to support an individualized approach towards ED. I highly commend the clear effort to strive for inclusivity and diversity regarding content and presentation (language) and the new focus on online versus face-to-face therapies.	The difference in style is because the recommendations on therapies for adults are based on quantitative efficacy trials, whereas the perinatal section uses qualitative research. Your comments will be considered in the evaluation of the inclusion of qualitative research in the guideline.
	DW	You will note that we do not feel qualified to comment on any clinical guidelines as a third sector community eating disorder charity. Our focus is on improving the lives of our service users by providing informal emotional support and peer support. However we do acknowledge that working together with NHS to provide a holistic approach is beneficial for people who access our services before, during and after formal treatment. We would therefore welcome the recommendations that acknowledge the need to improve existing services and address the unmet needs identified though engagement and consultations with all those affected by eating disorders	Thank you for reviewing the guideline.
	EB	Chapter 3 also seems to be missing any recommendations on provision of information for the patient – which makes it	This is covered in section 16. An information point signposting to peer support has been

		feel like this bit was written with a young child in mind. Also it should be recommending that services signpost patients to sources of non-clinical support like Beat. Also there is nothing on peer-support of any kind it seems. Tailoring treatment and person-centred care is only mentioned in the 'Needs of Diverse communities' section 15, and this section focuses on males, BAME people and LGBTQ+ people. Of course tailoring treatment/person-centred care is important for all patients and reflecting this in the Guideline could also be a good opportunity to highlight how this is particularly important for patients with Autism.	added to Section 13. We agree that tailoring treatment is important for all individuals. A reference to the PEACE Pathway has been added to section 1.2.1, along with a paragraph stressing the importance of holistic treatment.
	DS	Just to advocate further for at least a mention of occupational therapy! There are a network of us who meet regularly and I'm sure all would be happy to contribute. I know there is a lack of research papers, but there are some interesting papers around. I have included some below: Occupational Dysfunction and Eating Disorders Theory and Approach to Treatment Roann Barris EdD OTR Occupation focused assessment and intervention for clients with anorexia Kumari Abeydeera, Suzie Willis, Kirsty Forsyth Occupational impact of anorexia nervosa: occupational meaning, motivation and engagement August 2013British Journal of Occupational Therapy 76:42-42 Nicky Godfrey at University of Surrey	Unfortunately there is not enough evidence to include it. We have added a sentence in section 1.2.1 to highlight that OT is an integral part of care for people with ED but that there is a lack of evidence at present. We have also added a call for further research in section 18.2 Opinion/review article from 2008. Outside date range (2006). Descriptive case study of 7 participants. Qualitative study. We would not use this to answer a question on efficacy of a therapy.
	KBr	Within Annex 1, question 16, was there any supporting evidence to show the increased risk of reduced bone health and osteoporosis, and co-morbidities, which would indicate the role of Physiotherapy being considered as part	The role of physiotherapy in bone health is covered in section 12. Little evidence was identified, however, reference is made to the Physiotherapy Eating Disorder Professional Network and the Royal Osteoporosis Society and Chartered

		of the professionals list involved in SEEDs care pathways? Thank you for inviting me to be part of a fantastic review. The consultation sessions I attended were very helpful and informative. It has also been extremely positive to see Physiotherapy input discussed within the guidance as well as the inclusion of exercise management, supporting the emerging evidence.	Physiotherapists Mental Health guidance.
	LS	Significant absence of ARFID recommendations.	There was no evidence for ARFID. This is explained in section 1.2.1.
	SG	As a carer supporting someone with an eating disorder I think this is a fantastic information source and guide and I would have found this really helpful at the start of our journey. I notice that there are plans for a similar guide for carers/patients it would be ideal if these documents could be simple, practical guides with checklists and pointers. I'd be very happy to input to this if that is useful.	Thank you. We will contact you with regard to the patient and carer versions.
	DC	Overall a very useful guideline and hopefully will lead to improved services and outcomes. Thankyou!!	Thank you.
	AMc	I wonder if there are any other ways of putting the guidelines out other than in just a written format. We all learn and take in information in different ways. People are busy but can listen to a podcast when doing other tasks. Is there any merit in some audio information. Thanks great work.	A video/social media format for younger people is planned. Thank you for the suggestion of the podcast. This will be considered when planning ways to publicise the guideline.
	PC	Just really that, as said, my main concern is a relative neglect of important members of the MDT in the treatment of EDs, such as Dietetics and Occupational therapy, in my opinion. Otherwise, I have no doubt I will be using this guideline to inform my practice in the future. I especially liked the focus on the journey of care.	The guideline development group recognise the important role that OT, dietetics, physiotherapy, SLT etc have in providing care to patent with EDs. As this is an evidence-based guideline it reflects the areas where there is published research. An additional paragraph has been added to section 1.2.2 to highlight the need for care to be multidisciplinary and that research is needed.
	WW	An excellent well-written draft clearly the result of careful consensus-making in addition to the scholarship involved in reviewing the evidence. Thank you for the opportunity to	Thank you.

		offer feedback. I note many of my comments may relate to observations more suited to a college statement rather than a EBM guideline.	
	KL	I think the guideline is an excellent piece of work. It provides a robust account of the available evidence and acknowledges the limitations of the evidence base.	Thank you.
	SGF	There is not enough research/evidence/variety to enable generalisation for marginalised groups like ethnic minorities, men with EDs, LGBTQ+ communities, etc. It would be good to explore whether the implementation of this guideline changes this situation and there is more equity in access. Socially and culturally sensitive outreach and liaison work will need to play an important part in raising awareness and reaching both colleagues and patients/carers. There may be a role for Third Sector organisations to work alongside mainstream NHS services in this.	Agree. We have added an audit point around use and experience of services for marginalised groups, which could help to measure impact.
	RCPL	The RCP is grateful for the opportunity to respond to the above consultation. We have liaised with our Advisory Group on Weight and Health and the British Society for Gastroenterology (BSG) and would like to make the following comments. Overall, our experts were supportive of the draft guideline: · Succinct global update of research and guidance around management options, in terms of psychological therapy and medications for differing age ranges and presentations. · Updates on FREED and transition were welcome, particularly the recommendation of a transition manager to ensure a smoother patient journey. · Useful update on SEED patients as they are often complex patients and there is little research into this area. · Good to highlight and update on more complex issues ie peri-natal and diabetes. However, our experts felt that there were opportunities	Thank you for your response.

		missed: · Training, in particular for physicians, is lacking in the curriculum for all specialities and needs to be addressed in order to provide early identification and management. Our experts note that increased training was a GMC recommendation following a recent Coroners case could also be a recommendation from this paper. · Physical health implications – there is no guidance on the physical health impact of eating disorders and how they are best identified and managed (aside from bone density). This is an area of little research and many people are not confident with this area and there are no clear guidelines on this when it is outside of an emergency setting. Community vs inpatient admissions, ie when to admit and where to. Although MARSIPAN addresses the acutely unwell patient, there is no mention of brief inpatient admissions for symptom control which can be very beneficial, but also there is no guidance on when to admit to an eating disorder unit bed.	This is an evidence-based guideline and there is little robust evidence that meets the SIGN criteria. We agree it is regretful that there is no evidence-based guidance on these matters. This is the business of specialist networks, local protocols and there are published textbooks providing experience advice. There is no evidence around brief inpatient admissions. We strongly encourage publication of evidence for the creative use of such inpatient admissions.
	SB	I have checked the guideline and am happy with it. No change is required.	Thank you. No action required.
	SMcC	Good guideline just needing some tweaks will be good to see this implemented.	Thank you.
1.1	AG	Excellent and clearly stated.	Thank you. No action required.
	JW	SAS agrees on the need for updated guidance to assist professionals in supporting people affected by eating disorders and providing patients and carers with clear expectations of care and support.	Thank you. No action required.
	AR	I agree that there was a need for a Guideline	Thank you. No action required.
	AGe	Adequate, well explained	Thank you. No action required.
	BC	Very helpful to have an updated guideline addressing the comprehensiveness and accuracy of the evidence base for	No action required.

		this population.	
	MMac	Needs to clarify what means by service provision	This is a concept that is generally understood by healthcare professionals, so prefer to leave as it is and clarify in the user and carer guide if necessary.
	KB	I think it understates the problem to merely say there is wide variation in organization of services: the truth is that lack of evidence base has resulted in wildly different practice across the nation based on individual clinician opinion and local culture.	Thank you for emphasising the findings but the commentary is obliged to be based on published evidence and the reflection is cited from the MWC report. Where there is a lack of evidence base diversity of practice provides a welcome range of options to be researched and the guideline strongly encourages audit and research of current practice.
	VL	Not sure that EDs are necessarily to do with weight, shape or calories especially ARFID - bit simplistic? 1.1.1 - good to see acknowledgement of the common issues raised	Agree. The severity of the preoccupation with these matters are what constitutes the disorder.
	FB	"Eating disorders (EDs) are characterised by preoccupation with weight, shape and calorie balance" I find this a narrow definition of eating disorders which could exclude patients with ARFID and younger patients. While there is a long section on patient perspectives there is nothing from the perspective of carers.	Agree that the important thing is the severity of the preoccupation with these matters and that certainly the picture presented across the disorders grouped as ARFID is somewhat different and requires separate recommendations. We have been careful not to imply that the treatments which are evidenced to be effective for AN, BN or BED would also be effective in ARFID. Section 1.1.1 reflects feedback from patients and carers. The wording has been adjusted to make this clearer.
	AH	Under common issues No suggestion of a need to have awareness of how having an Autism Spectrum Disorder can impact on the care and treatment for someone with an Eating disorder	This is covered under the point that services need to be adapted for those who neurodivergent.
	HC	There is a definite need for a guideline which is closely adhered to by all NHS regional services. They must all "sing from the same hymn sheet" so that patients who relocate can do so seamlessly, e.g. students going to university. This section states that there is a "wide variation in the organisation of services for people with eating disorders across Scotland" This needs to be	Agree. Implementation of the guideline should address the variation in practice. Carers have been involved in the development of the guideline and their needs considered in section 3.2.

		addressed as soon as possible, Great to see that patients are being involved in the remit of the guideline. Carers should also be involved.	
	CV	Good overview and useful have common issues raised by patient groups.	Thank you. No action required.
	HB	I commend in particular the avoidance of 'gendered' language and the openness towards male, non-binary and BAME groups.	Thank you. No action required.
	DW	As a voluntary organisation we welcome the new Guideline and the involvement of people with eating disorders in providing lived experience to influence a more positive inclusive approach to formal treatment. The guideline addresses the inequalities experienced by many service users who contact us looking for support in their journey to recovery.	Thank you. No action required.
	JMc	Point about treatment currently focusing too much on weight as a marker of the patients poor health is something key to look at and promote change on, treatment should be preventative where possible and this way of focusing on how people maybe don't fit parameters can worsen the condition. Would agree on all points about the need for change.	Thank you. No action required.
	AT	The need for a new and revised guideline for Scotland has been identified previously by MWC and we are delighted that this has now been completed.	Thank you. No action required.
	DS	Clear and helpful.	Thank you. No action required.
	DC	Introduction is clear and sets out the need for a guideline. Highlighting the patient perspective is helpful - as a parent I was aware of how unhappy my daughter was with the use of weight as main measure of need for treatment and to decide if recovered. As a paediatrician I'm aware that guidance given to us regarding referral often uses weight. Highlighting the poor transition when reach adulthood also important as in our case all support stopped as "not severe enough". Primary care in our case did not feel equipped or	Thank you. No action required.

		trained to manage.	
	RT	It is positive that clinicians in Scotland have agency and expertise in all areas of clinical practice and are able to make their own evaluations of evidence in a devolved and separate health service. The process itself is vital as a marker for the need of the government to continue to fund research and critical evaluation in Scotland. In terms of what has been revealed, however, there is very little new information gleaned that is not already known and this is both on the one hand, not surprising and on the other, worrying. By this I mean, these guidelines serve to reinforce the conclusion that we still do not have any convincingly effective interventions.	Agree, perhaps the picture is not as dark as is suggested because a certain number of effective interventions, including new interventions has been identified in the course of developing the guideline and that sadly there are also many other medical disorders where this is the case but the provision of a guideline stimulates further research, as we hope ours will.
	AMc	I know AEFID is mentioned further on though when I first read this I wondered what about ARFID as some people consider it an eating disorder and some an eating disorder. 2nd paragraph line 7 typo nervsa rather than nervosa In the first paragraph it mentions that not all disorders of eating are eating disorders and then 2nd paragraph line 8 it mentions “disordered eating among sexual minorities”. I wonder if this is a little confusing. There are high rates of disordered eating amongst other groups (athletes, dancers etc) however this document focuses on eating disorders. 3rd paragraph mortality has been broken down into adolescents and adults I wondered if the 50% could be broken down into both these groups. The focus here is on AN what about BN and BED? 4th paragraph “can cause severe disruption to …” every aspect of an individual’s life including relationships, functioning, education….” “Caring for someone with a severe eating disorder” I wondered what the definition of severe was.	ARFID is still a relatively new set of diagnoses and because there are significant differences in the core psychopathology of other EDs we cannot extrapolate from other research and are still waiting for specific research on ARFID. Typo amended. This is an example of the range of the condition, and that it is not just a focus on females. This is because the mortality for AN is strikingly higher. Mortality figures for BN and BED are conflicting. This is a qualitative term that we cannot further define here, but that we agree that there has been disagreement about definitions of ‘Severe and enduring eating disorders’. The controversy has been more about how long the condition should have endured rather than levels of severity per se. This is discussed in section 13 of the guideline.

		Page 2 Point 1 My preference would be to change perverse to "unhelpful incentive to lose more weight" Point 6 Treatments to be more inclusive or is it inclusive? I wonder if it is better to put identify as rather than are.	Prefer to leave as is as the meaning is less passive than 'unhelpful'. Changed to more inclusive. Changed to 'identify as'.
	PC	Good introduction to the subject and the need for a guideline. Helpful that section on patient perspective is early on, but would query the lack of specific sources or references for the listed elements in Section 1.1.1	A paragraph has been added explaining that the issues listed were identified through a survey of patient and carer groups and via a focus group.
	WW	Good, clear, eloquent. I have focused my comments on areas below, where blank I had no comment to add. A carefully prepared document which reads very well.	Thank you. No action required.
	SGF	This section highlights the significantly lower referral rates in BAME and minority backgrounds but also needs to reflect the slightly different nature of symptoms/complaints in these populations that may lead to these cases not being recognised (for ex. Akan et Grilo 1995). Ongoing comparative research in UK minority populations needs to be done. Would be useful to include culturally appropriate third sector organisations as part of the planning to improve access and follow up- support	Further advice on managing patients from minority ethnic backgrounds has been added to section 15 and Annex 1. There is a recommendation for further research in section 18.2 This is for the National Review Implementation group
1.1.2	AT	Section 1.1.1 and section 1.2.5 described patient perspective and 1.2.5 described a patient and carer version of the guidance together with an EQIA. Given UNCRC describes children's rights to voice their views on matters that affect them and also the right to access information then hopefully patient perspective was included children's voices and also the patient and carer guide considers a child friendly version given ED are a common mental disorder affecting under 18s.	The needs of children have been identified in the EQIA. Prior to starting the guideline a literature search of patient and carer issues, inclusive of children, was conducted, and patient and carer groups were invited to submit issues which were discussed with the guideline development group for consideration when setting the key questions. An easy read version of the guideline will be produced, and used to produce YouTube videos aimed at children and adolescents.
1.2	AG	Thorough and wholly apposite.	Thank you. No action required.

	JW	Appropriate	Thank you. No action required.
	AR	The remit is appropriate	Thank you. No action required.
	AGe	No issues	Thank you. No action required.
	BC	As a specialist speech and language therapist who has worked with this population in acute paediatric settings I was surprised to see that speech and language therapists were not included in the list of target users of the guideline	Apologies for the omission. This has been added.
	MMac	Needs to states that remit is not to make resource recommendations and reason for this	There are always resource implications for recommendations. These will be considered by the National review Implementation group. Any significant implications would be highlighted in the guideline.
	KB	Refreshingly transparent comments on determinants of service provision. I think stating common (and defensible) practice in a guideline is a good way to protect clinicians from undue criticism/blame. It may be worth restating need for caution when extrapolating evidence to patient groups not represented in the research (while still supporting pragmatic need for this at times). The long-overdue inclusion of exercise in guidance is a positive step.	Where we have extrapolated or suggested extrapolation we believe we have drawn attention to the need for caution, but will bear this in mind as we review the final draft.
	FB	I welcome the commitment to inclusivity, but feel that, because of the lack of evidence, the actual guidelines do not contain much of interest or use to, for example, those with autism or personality disorders. The guidelines concentrate on the psychological and pharmacological therapies available and not on the environment within which services sit. I recognise that both the current shortage of psychiatrists and the geography of Scotland are outwith the scope of the guidelines but they, and the structure and resourcing of health services in general are vitally important in treatment	Agree – delighted that SIGN will be published at the same time as the work of a national implementation group that will examine precisely the service environment and workforce.
	CV	Beneficial to keep in explanation of why ARFID was excluded from this review as people may have been expecting its inclusion - would it be useful to sign post to any other sources here (or not possible as not evidence	We have added a signpost to the PEACE pathway in sections 1.2.1 and 16.2

		based?) would target users also include school counsellors, who aren't teachers instead of specifically ASD (or now commonly referred to as ASC in research) would saying Neurodevelopmental disorders NDD be more inclusive of comorbidities we see in practice?	
	HB	I would have liked to read a short sentence why the focus is on AN. BN and BED, and ideally would have liked to see an opening towards other EDs.	The paragraph includes the sentence: 'Advice for treating people with EDs which do not entirely meet formal diagnostic criteria is to follow guidance for the diagnosis most aligned with their difficulties.'
	EB	Is Beat able to provide input on these before they are published?	The patient versions will be circulated for comment prior to publication.
	JMc	Part about what constitutes recovery from an eating disorder, whether or not weight should play a part in this - very difficult one as there needs to be a physical recovery involving increased weight in most cases for the patient to have cognitive changes from when in ED but shouldn't be the main point focused on, i.e. weight AND reduction in disordered thinking/actions, improved quality of life etc	We absolutely agree but our recommendations were limited by what has been measured in the research to date. Because the disorders are characterised by a pathological fear of maintaining a normal healthy weight, it is a hallmark of psychological recovery to maintain a healthy weight, not just about physical health.
	DC	Clear and broad remit. Good to highlight comorbidities. My daughter was also frustrated by the lack of a joined up approach - Camhs for depression/self harm and eating team for anorexia. Communication often poor and each treated in isolation. Although the remit is for all health professionals in different setting my feeling was that as a general paediatrician there was not a lot of guidance regarding identification of ED, pre referral investigations/monitoring or referral guidance. Also we often have admissions to our ward when there are not any specialist beds - most doctors/nurses know very little about how to approach feeding children/young people with ED, the vigilance or monitoring required - this maybe outwith the remit of this guidance though	Whilst some of these issues have to be addressed by service reviews, we have attempted to highlight the dangers of multiple aspects of transitions in section 3.5.
	RT	The guidelines are constrained by the research which itself is mostly historic and constrained by diagnostic criteria	A lot of the historic research has been disqualified as the search criteria was limited to 10 years, so most of the studies

		from DSM 3 and 4 and ICD-10. There are now new diagnostic guidelines with different symptomatic criteria generating new classifications. There is a limit to the degree to which the historic data existing in one defined group can be extrapolated to newly defined groups and this needs to be acknowledged in qualifying statements.	were in DSM IV or DSM 5. However, also, quite a lot of research included participants who might not have fully met those criteria. Newer criteria tend to be less restrictive so might have included those subjects. On the whole we were reasonably confident that research subjects reflected our patient population. As you imply, the presentation of eating disorders as well as their definitions has evolved over time. This is covered in section 1.2.3.
	AMc	Eating disorder clinics I would change clinics to services. Page 3, Comorbidities Is pregnancy a pre morbid condition or a normal state? Schizophrenia is on the list, what about psychosis? Some people have psychotic episodes without this diagnosis. Definitions and treatment outcomes. 2nd paragraph, last sentence I wondered about excessive exercise after binging as part of BN to prevent weight gain. 3rd paragraph, 2nd sentence “lose weight easily by omitting insulin rather than by diet” would it be clearer to insert restricting diet or energy deficit.	Changed. The mental health condition is the comorbidity. Reworded to clarify. Changed to : Psychotic conditions including schizophrenia and bipolar psychoses Added. Changed. Thank you for helpful comments.
	PC	Important definition of the task of the guidance. I do query the lack of more specific mention of other physical comorbidities-just Type 1 Diabetes. Can perhaps understand why others might be excluded (lack of evidence base for example), but other physical co-morbidities that influence treatment choices and effectiveness are very common.	We have included in the list, and part of inclusion for the search strategy but no evidence was found. More detail has been added to the list of likely conditions.
	WW	I noted the lack of evidence for ARFID, but as this is a question which will be asked of services it is a pity a section cannot be included summarising current understanding of this diagnosis and explaining there is not sufficiently evidenced treatment.	There was insufficient evidence to include a section. We have added a reference to the PEACE Pathway which has some expert opinion-based advice on ARFID.
1.2.2	VL	1.2.2 Good to see mention made of neuro untypical issues - particularly ASD which accounts for a high proportion of	Thank you.

		those with ED. Agree that co-morbidities need to be considered and not all about weight.	
	AT	Refers to comorbidities that have been considered, but there's very little to guide the target audience about what to do with some of these e.g. schizophrenia, OCD, substance misuse. There's very little on PD, yet the guideline notes that 30% of ED patients have a diagnosis of symptoms associated with PD	All comorbidities listed were part of the inclusion criteria for the evidence review, however, very little research was identified. A call for further research has been made in section 18.2.
1.2.3	AT	This is a very useful overview of some of the main things that are wrong, specifically in relation to the diagnostic assessment and the lack of evidence. In other parts of the guideline it is highlighted where different evidence and other interventions have provided a different insight into the challenges faced; could this be considered in this section, specifically with a point about assessment and the wide use of BMI.	This is general information to explain the definitions used in the guideline and it is preferable to keep this concise. There is a reference to a qualitative study which readers can follow up if more information is needed.
1.2.4	GA	The list of practitioners is not inclusive of the wider practice team commonly seen in primary care. To be more inclusive could the committee consider adding a statement to include all health care practitioners within primary care rather than singling out GPs and nurses.	The list starts with the sentence 'This guideline will be of interest to primary, secondary and tertiary healthcare professionals'. It is not possible to include everyone, however we have added some additional specialties. We prefer to retain GPs in the list, and nurses may also refer to staff in secondary care too.
	SY	Inclusion of Psychotherapists and/or The Arts Therapies. I personally found the original guide's information, especially the references, were extremely useful in my training placement as an Art Psychotherapist on an Eating disorder unit.	It is not possible to include every specialty in the list, however, the section begins with the sentence This guideline will be of interest to primary, secondary and tertiary healthcare professionals' and 'art therapists' has been added.
	AT	It notes "will be of interest" – is there any other application for this guidance. Perhaps that can be spelt out here given the broad membership of the audience.	This is guidance only. A statement of intent is included in section 1.3.
	AMc	Dieticians is the American spelling. In the UK we use dietitians.	Spelling corrected.
1.2.5	AT	Section 1.1.1 and section 1.2.5 described patient perspective and 1.2.5 described a patient and carer version of the guidance together with an EQIA. Given	The needs of children have been identified in the EQIA. Prior to starting the guideline a literature search of patient and carer issues, inclusive of children was conducted, and patient and

		UNCRC describes children's rights to voice their views on matters that affect them and also the right to access information then hopefully patient perspective was included children's voices and also the patient and carer guide considers a child friendly version given ED are a common mental disorder affecting under 18s.	carer groups were invited to submit issues which were discussed with the guideline development group for consideration when setting the key questions. An easy read version of the guideline will be produced, and used to produce YouTube videos aimed at children and adolescents.
	SGF	1.2.5 +/- 1.2.6 would be useful to have official translated versions in major languages (or arrange for bespoke translations upon request) for patients and carers	SIGN guidelines are translated into other languages on request.
1.3	AG	Clearly documented and readily understandable/ appropriate	Thank you. No action required.
	JW	Appropriate	Thank you. No action required.
	AR	This is clear	Thank you. No action required.
	AGe	Well explained	Thank you. No action required.
	KB	This also feels very supportive to clinicians - particularly not to get stuck rigidly on following a recommendation when individual patient factors may warrant departure on occasion. I think in risky situations, clinician anxiety often produces unhelpful/blind following of all guidance to avoid blame rather than sometimes vital "positive risk taking" to move on from entrenched risky behaviour.. There is a lot of good sense that is nevertheless very helpful to state explicitly.	Thank you. No action required.
	HB	This covers well what the guidelines are NOT intended to do. It would be helpful to make a nod to what the guidelines CAN usefully do.	The objectives of the guideline are described in section 1.2.1.
1.3.1	AMc	Bias can also come from fidelity to a treatment / therapy model. Or fidelity to a specific treatment model.	If this means preference for a particular model we agree that this can be a source of bias but is not a conflict of interest unless the person stands to gain from it, in which case it is covered by financial or academic interest. Any bias is mitigated by discussion with the multidisciplinary group and independent information professionals appraising the evidence.
1.3.2	SGF	Would we want to add after the last paragraph	

		The prescriber would be cautious of pharmacogenetic differences between ethnic groups when prescribing.	This would also apply to age weight and gender, so we would expect any prescribing to be tailor-made to the individual. A sentence has been added to that effect.
General	AG	Well set out.	No action required.
	JW	To be determined following feedback but range of topics and issues covered appears comprehensive.	No action required.
	AR	Seem sensible to me	No action required.
	AGe	Clear	No action required.
	AL	It is vital if this guidance is to lead to improved care and support that there is explicit inclusion of input into services from Music, Art and Drama therapists	See response to FH comment on p10.
	MMac	Presume there will be a summary of recommendations in section 2	This will be available in the final version, along with a quick reference guide of all the recommendations.
	KB	See comment above on including exercise. It is so important to hold evidence in higher esteem than avoiding breaking taboo. I strongly agree that "female athletic triad" is a way that athletic organisations/coaches/athletes unhelpfully minimise eating disorders in sports.	A good practice point on ED in sports is included in section 3.3.2. The additional term, 'relative energy deficiency in sport' has been added to the statement.
	FH	Why has art therapy not been included in the psychological therapy treatment options? Art Therapy can be a first line intervention for children and adults with any eating disorder, incorporating a psychoeducational component and adopting an MBT informed focus.	See response to FH comment on p10.
	CV	Once added here in final version would it be useful to explain difference here in recommendation vs additional comment - which comes latter but perhaps earlier here could be helpful?	The additional comment is to provide background information to the recommendation. This will be self-explanatory now that the text is in place.
	DW	The Key recommendations address many of the issues that service users have experienced which has led them to seek peer support and one to one befriending support before during and after treatment. The need for early intervention, acknowledgement of the complexities of comorbidity and the lack of support for people with eating	Comments noted. The key recommendations were not available in the consultation draft, but have been agreed through a consensus exercise amongst the multidisciplinary guideline development group.

		disorders and support through transition are particularly welcomed in addition to support for carers and a more holistic approach.	
	AT	Overall, the guidance is very helpful. Occasionally we found it rather lacking in specificity about practise overall in terms of addressing common issues in practise. Section 1.1.1.notes the patient perspective and common issues raised, with the first point about the use of weight as a sole measure, but the guideline makes little or no reference to this other than in the recovery section on page 9. If there's not to be a focus on this, then the guidance should mention where the target audience can better understand where/how/who will make this change.	This is raised because the research often uses weight gain as the most conveniently measured outcome in the management of AN. This was raised by the patient and carer groups highlighting that weight gain alone does not constitute recovery and that weight loss alone is not the only indicator of severity and need for treatment. There are other measures of symptom change, mostly relying on a range of questionnaires and interviews describing quality of life, level of function and mood. Section 18.2 calls for agreement on the best outcome measures to be used.
	PC	Await these to be summarised-there are a lot of important findings to choose from. I don't know if the issue of sufficient resource for research in Scotland could be one of the key ones.	Resource will be addressed by the Scottish Government's Implementation Group.
3.1	AG	No issues.	No changes required.
	AR	Where ever possible it is best	No changes required.
	AGe	Good summary of research	Thank you. No changes required.
	EM	I don't see a strong enough statement on the need for intervention. The NICE guidelines wrote "People with eating disorders should be assessed and receive treatment at the earliest opportunity." and even that is vague. I appreciate there may be no studies to justify treatment starting within 1 week, but does the experience of clinicians not count? There seems to be a lot of informal agreement about early intervention meaning a week or so, not 3 months or 3 years	The FREED model has recommendations for time from referral to assessment and then to treatment and these are audited. There is no evidence to guide a recommendation on specific timescales at present. This is something that will be considered by the Scottish Government's Implementation Group following the national review of eating disorders. The text has been amended to say that patients should be seen as soon as possible.
	AL	It is vital if this guidance is to lead to improved care and support that there is explicit inclusion of input into services from Music, Art and Drama therapists	See response to FH comment on p10.

	KB	I very much welcome the acknowledgement of the critical interval for intervention, however I would take this far further: This is emerging as such an important issue on guiding how "aggressive" treatment should be. If early, then brisk refeeding and suspension of life to focus on that is justified. If >3yrs, that approach is not likely to be worth the intense distress and disruption of life-trajectory. In my view, evidence should be further categorised according to illness stage/duration. I'm aware the draft updated NICE guidance does this with striking differences evident in early vs chronic illness (regardless of age).	There was unfortunately no published evidence to guide taking our recommendations further. There are different views on the staging model of eating disorders, and possibly different views between adolescent and adult services. There is currently no robust evidence to guide aggressiveness of treatment depending on staging of treatment.
	FB	I would welcome more data on the outcomes of FREED as promised in 2017. However I recognise that the pandemic has had a major effect on all aspects of healthcare including research.	The FREED model has been rolled out in the Freed-UP study and has now been commissioned across NHS England. All sites will be providing data to FREED so that further evaluation and publications will emerge in due course.
	AH	Add a Best practice - to direct clinicians to consider those with ASD. May require a different care approach which needs to consider the drivers behind the ED may be due to the early unrecognised traits of Autism e.g. sensory sensitivity, social anxiety, interoceptive problems	This is covered in section 3.3.3.
	HC	Where possible, early intervention is most appropriate. However, in order for this to have optimum benefit GPs, occupational health professionals, teachers and all nursing staff, especially school nurses should have some basic training in how to spot the signs of an eating disorder and how to deal with it on a basic level. We have just recently had a school nurse emailing our charity to get information on eating disorders in order to help a pupil in one of her schools.	Agreed. Early detection relies on education of these professionals. Recommendations were made on this within the Scottish Government's national review of eating disorder services and will be taken forward by the Implementation Group. A sentence on this has been added.
	HB	I really like the title of this 'Framing the journey of care'. As a humanities scholar I commend the good choice of words. Finding the best frame to word content is vital important for healthcare professional. However, I did not see immediately the link to the recommendation of an additional FREED service: Why is it called a 'pilot' if it's been in existence? What is the reason the have more of the same rather than investing in	The original publications and subsequent follow up were from a pilot group. The model has been expanded in the 'FREED-up' study with more participants. It is now being commissioned across NHS England and all sites will provide data to FREED adding to the data and evidence base.

		something new? Perhaps this could be outlined clearer?	
	DW	Our Carers feedback makes clear the need for early intervention and we welcome the recommendations that acknowledge the need for more community based support to reduce the number of hospital admissions and the approach that currently requires only the most acute cases being admitted and discharge relating to acceptable weight gain. We also would like to see schools being made more aware of the dangers of eating disorders and staff training that helps identify pupils at risk and how to seek support. We feel that the voluntary sector can contribute to this area of need.	Early detection relies on education of these professionals. Recommendations were made on this within the Scottish Government's national review of eating disorder services and will be taken forward by the Implementation Group.
	EB	That recommendation is great (although its more service provision/policy than clinical practice so surprised to see it in here). But there should be others, including around early identification and immediate referral for specialist assessment (as NICE has). It is useful then for campaigners to be able to point to this as a counter to the classic 'watchful waiting' approach from GPs or GPs trying to run their own triage for the service.	There was no evidence related to this. The issue was raised in the Scottish Government's national review of eating disorder services and will be taken forward by the Implementation Group which is due to start meeting shortly. Early detection relies on education of these professionals. Recommendations were made on this within the Scottish Government's national review of eating disorder services and will be taken forward by the Implementation Group.
	DC	Emphasis on early intervention helpful and good to show how affects outcome	Thank you. No changes to the draft required.
	AMc	1st paragraph, last 2 sentences I'm not sure about "normal weight or higher weight ED". It seems we should be moving away from this focus. Sometimes a "normal weight" person may be bingeing and vomiting with hypokaleamia. As well as physical symptoms there can be enormous emotional distress. One could argue that this is urgent for this individual and their family. Would worsen the drive to lose weight read better with increase the drive to lose weight. Is there a specific rationale for the FREED study being 16-25 with an ED of less than 3 year duration? I'm wondering if it is acceptable to discriminate positively or negatively	These sentences have been removed. This was the original criteria used by FREED. The evidence suggests that early intervention, particularly in adolescents and

		based on age. Later in this document it mentions that duration of illness had no bearing on outcome so I'm wondering if this is contradictory. It is unclear if FREED comes from research that indicates greater recovery in this age group.	younger adults with developing brains is very important. This was the reason that the researchers chose this age group, and these criteria.
	PC	I do like this section and its intent-framing the journey of care. Treating EDs and trying to work alongside patients and carers has to keep a bigger picture in mind about the overall journey, and I think that can be a helpful stance to relieve anxiety about the here and now challenges. My main query about this is why no prevention work was included in the scope of this guideline? There is a significant literature in this area and I would have though if early intervention is in scope then at least some rationale why prevention studies could not be included would be important. The starting point for many is sub-syndromal conditions where prevention type work could be vital.	Thank you for this point. The guideline already had a broad remit, and it was felt necessary to keep the focus on management. Prevention may require a separate guideline to do it justice. This was raised during the Scottish Government's national review of eating disorder services. It will be taken forward with Public Health Scotland by the Implementation Group.
	SGF	Outreach and liaison work needs to be included in services as an additional task to achieve FREED integration to adult services - how can this be incorporated? A named person in each service to manage this?	This is a helpful comment, however, we did not review any evidence that would support a recommendation about this particular issue. The Scottish Government's Implementation Group taking forward the recommendations of the national review of services should be able to take this forward. The review made recommendations about named clinicians in each area being responsible for issues like this.
3.2	AG	No issues and carefully considered.	Thank you.
	AR	Good to include this	Thank you.
	AGe	Good	Thank you.
	EM	I welcome that this has been covered. Thank you for writing "There may be some conflict between advice given to parents using this model and advice provided by family-based therapies " Would you spell out that conflict, for the benefit of readers who don't know what that might be? I am finding even experienced clinicians may not realise that it is confusing, distressing,	We would prefer not to go into details as the guideline aims to be concise. The aim of the statement is to support individualised care and thoughtful consideration of advice for carers which may be inconsistent. It is hoped that highlighting the evidence for group-based approaches means that such support will be prioritised in holistic care.

		disempowering, for a parent to learn they should be a gently guiding nudging dolphin, when they are ALSO asked in FBT to take charge of meals and be persistent in intervening in behaviours. Would you also consider indicating that parents may benefit from support groups such as FEAST-ed or such as those run by various CAMHS? I understand there may not be published evidence.... However I also would appreciate all CAMHS giving parents info on online resources such as FEAST's, especially when placed on a waiting list.	FEAST has been added to section 16.2, sources of further information.
	BC	ASD and AN have a high degree of co-morbidity. Early identification of ASD for young people with AN and early involvement of speech and language therapy to advice how diagnosis is likely to impact on family based treatment could improve outcomes Working with families and carers in an ASD informed way whereby communication is adapted to support the young person is likely to reduce stress and avoid ineffective strategies.	We agree that a multidisciplinary approach is needed. The guideline has focused on areas where there is published evidence. However, in section 18.2, a call for further research for involvement of other disciplines has been added, and a sentence has been added to the introduction to acknowledge the value of multidisciplinary care.
	AL	It is vital if this guidance is to lead to improved care and support that there is explicit inclusion of input into services from Music, Art and Drama therapists	Please see response to FH comment on p10.
	KB	Again, transparent comments on liability for therapy to have adverse effects are refreshing. We are far too hesitant to consider or acknowledge this. Helpful clarification that generic advice does not breach confidentiality.	Thank you.
	MS	Parents and carers have been shown to experience high levels of emotion, caregiver burden, distress and difficulties coping. 28,29 The significant psychological impact on carers can lead to the presence of ineffective strategies for managing an ED, which may inadvertently exacerbate patient distress and, in turn, ED symptoms.3 I am a bit unhappy about the wording here, which implies	This statement is not intended to be parent blaming. It is intended to highlight the very real and significant stress that carers can experience and the impact that has on the whole family to provide a rationale of why such support for carers is essential in all services, including adult services. We have also attempted to incorporate concerns about parents being excluded and how services can provide support without breaching confidentiality. The word 'inadvertently' has been replaced with

		parent-blaming. One of the failings of the system at present in many places is for adult services to want to exclude parents/families. Individual psychological work once a week with an adult patient can leave a patient isolated and it is understandable that families want to intervene to be supportive when they are with the patient all week. I am not convinced that the guidelines cover for this eventuality - although I read that patients are encouraged to find and use support.	'unintentionally'.
	FB	I myself have benefitted from the support gained via a course run by the Maudsley team on the ECHO model but I do realise that it was developed for use with adult patients. I think it is important to recognise, as the guidelines do, that "There may be some conflict between advice given to parents using this model and advice provided by family-based therapies" Courses based on ECHO, as BEAT intend to offer, may not be suitable for ALL families. I would also like to see much more support for siblings.	Thank you for the comment. No change to the draft required.
	HC	In our experience, most families, carers and friends want some knowledge for themselves in order to help their loved one. They do not want to breach confidentiality. They want to help. Therefore quality time needs to be set aside to give them the appropriate knowledge, to answer any questions, to give them feasible strategies, to direct them to support networks and most importantly to give them hope.	Thank you for the comment. No change to the draft required.
	CV	Great this is covered. The parents of adolescent patients may be asked to participate in family-based treatments - would we say parents/carers or main caregivers of adolescents as not always parents. Overcoming Anorexia Online demonstrated greater reduction on carer distress compared to less intensive interventions - but not included in the summary of	Thank you for pointing this out – "and carers" has been added in here. Overcoming Anorexia Online was not included as it was one of the interventions which was only compared to a less intensive intervention (in this case access to BEAT carer phone line when required) therefore we chose to focus our recommendations on interventions which have been compared to more active treatment comparisons.

		recommendations?	
	HB	Really appreciate the emphasis on this but see some scope in phrasing 'family' and 'parents' more carefully and openly to be more inclusive of non-traditional settings. Perhaps just add a half-sentence to make a nod to diverse concepts of 'family'/'parents'.	The section has been revised so it is stating parents or carers and if only one term is used carers is used as a global term to cover a range of supports.
	DW	Providing support information and education to families and carers is welcomed and as an organisation that provides peer support and one to one support for carers we understand how intensive the treatment can be. Families and carers should feel equipped to support and manage their loved ones eating disorder to the best of their ability we also feel this is an area where the voluntary sector can provide more informal community support. The need for good links between NHS and third sector services could be further strengthened by creating better referral pathways and improved communication.	Thank you. No change to the draft required. Links between the third sector and the NHS should be addressed in implementation plans.
	EB	Page 12 - Services should offer and/or signpost family and carers to support like ECHO and care skills workshops even if their relative/friend is not on the caseload – we managed to get this into the commissioning guidance for Adult ED services in England.	Agree. This has been added to the good practice point.
	JMc	I think this is why FBT works well for young people with an eating disorder who maybe can't fully articulate the struggle they are facing. Having a period of time each week where the patient and their family can be together with a professional to both learn and progress is extremely helpful for both parties. I think extra support for parents/guardians would be beneficial also, not sure if this would just be in the form of letting them know exactly where to find the right information on how to cope/deal with situation or maybe running sessions just for parents to get a better understanding/support that they need.	Thank you for the comment. No change to the draft required.
	AT	Found the treatment options in relation to carer support programmes particularly useful information - especially with the level of evidence having scores of 1 - and the	Thank you.

		strength of the recommendation. A very positive step towards better carer support.	
	LS	This is really important as a CAMHS clinician and to support consistency nationally. CAMHS lothian have run a parents/carers support group for many years, usually a short course of 5-6 sessions. Parents feedback is usually around the support they get from meeting others, we have adapted the framework of this group (previously collaborative carers) to support more open dialogue/discussion between parents. We also have guest speakers - Beat Young Ambassadors and Carers with lived experience. Feedback is always very postive about these sessions and fits with the ECHO approach and the power of someone sharing their own experience/hope.	Thank you.
	DC	Family based treatment can feel very DIY for parents and causes a lot of distress to siblings Support is essential emotionally and on a practical level For us dietetic support was very limited and it'd be helpful to highlight the need for dietetic support too. The use of online programmes was very interesting and the use of expert carers giving practical advice invaluable for other families. My daughter found mixing with other sufferers difficult as there were concerns re "will I be the fattest" etc so some caution re this.	No evidence was found for dietetic support in FBT at present. This would be useful in textbooks and training programmes but no evidence to include in evidence-based guideline.
	PC	A vital section outlining the current evidence base for these, growing and developing, interventions.	Thank you.
	SGF	Need more research for peer support in BAME and minority communities as uptake is low in these groups for carer support - May be helpful to use existing third sector minority organisations like BINA, Saheliya etc. locally to raise awareness and offer support in the community alongside NHS services - Culturally appropriate Carer support sessions as a package can be included for every patient, especially in the younger/first episode category +/- interpreters.	We agree, and have included a specific call for more studies into groups who are under-represented in existing research, including minority ethnic groups. We will contact the groups suggested to raise awareness when the guideline is published. This is covered in recommendations in section 15.

3.3	AG	No issues.	Thank you.
	AR	Relapse remains an issue	It is hoped that the good practice discussed can help to address that.
	AGe	Good	Thank you.
	AL	It is vital if this guidance is to lead to improved care and support that there is explicit inclusion of input into services from Music, Art and Drama therapists.	Please see response to FH comment on p10.
	MMac	Physical activity guidance is good but recommendation could include more evidence from community based interventions as a lot of the evidence relates to inpatients where it is easier to manage activity.	Agree. Unfortunately there was no evidence. A recommendation for future research has been added.
	KB	Glad to see exercise included. I think it is important to highlight gaps in evidence and dangers of extrapolating too freely.	Agree. Gaps in evidence have been highlighted for research recommendations.
	EM	Please would you review the wording of 3.3. with great care. It is open to misinterpretation. As I read it, the first paragraph seems to stress that a patient's definition of recovery can be problematic and is not a hallmark of true recovery. Then in the 2nd paragraph, one could get the impression that it is OK to accept the patient's view if they cannot tolerate reaching a healthy weight. I find that 2nd paragraph confusing. If I have misunderstood this section, then that adds to my request that you re-word with care. I am very worried that in inexpert hands, a clinicians may give up on treatment while there is still plenty of hope, in particular if the patient is not SEED. My understanding is that even with a SEED patient, some experts are not happy for them to be condemned to being a functional anorexic: it is more a sign of clinicians having not yet found a successful treatment, than a sign that living with the illness is right for the patient. Let us remember that the patient's fear of weight, and their assertion that they would be very well if only people stopped trying to treat them, is part of the anosognosia	The second paragraph has been restructured and the following sentence added: Supporting patients to achieve a healthy body should be considered a viable option at all times to support psychological change and improvement in quality of life.

		that is part of the illness.	
	GV	Too little focus/has been placed on the link between higher weight and better mental health and reduction of symptoms. Research seems to indicate AN is caused by and maintained by reduced calorie intake (energy deficit). So the patient needs to have a certain calorie intake sand weight to recover. The inclusion of comments focussing on quality of life and patients view of quality of life could be misleading. The weight gain is difficult and frightening but the focus should be on finding ways to overcome this rather than the suggestion that it may be preferable to focus in quality of life rather than weight gain. The patient could be trapped in quasi recovery because the practitioner did not have the skill or time to push through the pain barrier of weight gain or behaviour changes leading to weight gain, and could point to these guidelines to excuse that, Focus should be on the link between full recovery and weight gain and the difficulties of achieving that in view of the clients ambivalence.	The paragraph has been changed to say that BMI should not be used as the only outcome measure An additional sentence has been added: However, from both the physical and psychological point of view, it is essential to provide nutrition for the brain to allow it to develop and function to live life to the full.
	VL	Ist paragraph - should it be "were"	Unsure where this is, but the draft will be proof read prior to publication.
	FB	I agree that re-feeding to an optimum weight should be offered routinely to ALL patients with Anorexia Nervosa. At present, in some areas, any treatment at all seems only to be offered to people with a life-threateningly low BMI. I would be interested to know the recommended settings for the refeeding given that there currently appear to be no inpatient beds available in the country. I welcome the idea of safe exercise programs but ideally ALL patients with ANY eating disorder should be managed by a suitably competent multi-disciplinary team. And yet the resources for this just are not there	This is a recognised criticism of access to ED services and whilst most ED units do not have a BMI threshold for admission it is typically the most physically compromised patients who are allocated the finite bed spaces, ie the patients presenting at the lowest weight. However, refeeding should be offered to all patients and can be safely and effectively achieved in the out-patient setting. The recommendation states that refeeding should be offered routinely to all patients.
	HC	We sometimes find that some group members stop coming for support when they feel confident and well enough, but their personal circumstances may change leading to the ED reappearing, or possibly professional help has terminated and they lack confidence in	Evidence on follow up interventions was considered and presented in section 3.3.4.

		maintaining recovery. This is when they may need the reassurance of other group members. For some, they may need further professional support, especially with exercise levels. We would like to ensure that this can be available for those who need it, to prevent a more critical relapse.	
	CV	A systematic review concluded that including supervised exercise training in the management of patients with AN is safe, as it did not result in additional weight loss and may have benefits in the areas of strength and psychological wellbeing. Exercise training was reported to improve strength and cardiovascular endurance despite no change in lean body mass. No significant impact on quality of life was reported, although, negative feelings for food and exercise were reduced. There was a reduction in anxiety and depression, improved body image, improved social behaviour, and a reduction in requirement for secret exercise. - for this paragraph would it be useful to state if this was with adult or young people population, where it was added in treatment, how much/what type of supervised exercise etc... as a clinician have a worry young people would read this paragraph, not read the actual study and interpret in a certain way that potentially maintains beliefs re over-exercising. The 2++ evidence is before the 1+ evidence perhaps order is changed in this paragraph?	Thank you for the comment. The paper refers to supervised exercise. We have clarified that this is an adult population, although the need to address dysfunctional exercise also applies to young people. The paper did not detail amount and type of exercise. Actual prescription can only be carried out individually at assessment, taking into account the many factors and not just BMI based. This is why we have referenced the SEES guidance. We have added the statement 'It can be used to guide practice but does not replace specialist assessment and clinical reasoning' and that assessment should be carried out by someone suitably qualified, to reinforce that exercise prescription needs an individualised approach. The 2++ evidence is given first because it is a body of evidence in a systematic review, whereas the 1+ is a single study.
	HB	I am not quite sure I fully understand the first two sentences. Could they be made clearer. 'Defining recovery ...'	The following two paragraphs have been revised which hopefully makes the context clearer.
	DW	Many of our service users feel let down following treatment and relapse is very high. More community based support could help to maintain recovery and the need for more specialist staff and links to other third service resources could be supported by the acknowledgement of more informal support. Feedback from our service users who	Accessing support services in the community are important for relapse prevention. The evidence for this is lacking, however, as clinicians we are acutely aware of this need and it is hoped that this may be addressed by the Implementation Group of the National Review. The section on follow up care, section 3.3.4 encourages signposting to what is available at present, listed in

		have struggled for many years suggest that maintaining recovery is one of the biggest challenges they face.	section 16.2.
	JMc	Not speaking from experience but something I would imagine would be difficult for someone who either doesn't identify with one sex/is transitioning - basing weight restoration on BMI ('healthy' levels different for male/female) might be another uncomfortable situation for someone who presents as different to their biological sex. I am not sure how best to address this but I would imagine taking a patient centred approach for each individual and understanding the stress this might cause (on top of an already difficult situation) might be helpful. On point about exercise too, I do think that it would be helpful to allow some guided exercise throughout treatment. Speaking from experience, going from being told not to partake in any physical activity to then being told I could was quite difficult, i.e. not knowing what was acceptable/normal levels, what was the right thing to do for my body etc. It is also difficult though, as very ill patients often need to stop movement to preserve their health, and there would therefore have to be a sort of guideline as to when exercise should be introduced, but using weight/BMI as a marker is again an issue for aforementioned reasons. Would again have to be a more personal approach taking lots about the patient's journey into account possibly. About co-morbid EDs - perhaps more training for professionals to spot these comorbid symptoms? Wasn't until I went to a private therapist that I was told it was likely I also had ASD which changed the way I thought about my experiences and might have changed how I handled treatment/was treated when I was younger in care for ED alone.	Dietitians involved in ED care, will take sex, gender diversity, ethnicity, and genetics into account when interpreting BMI and that is why it is not possible to give a clear BMI target. BMI does not differentiate between male and female in terms of presentation. Healthcare professionals are aware that most patients find BMI measurements stressful. An addition has been made to the recommendation for training in section 15.4 so that clinicians are aware of such issues. Thank you for this comment. Evidence is positive for the inclusion of exercise/movement as part of treatment within a Multidisciplinary Team This however can only be included if it is safe to be carried out. There are many factors to be considered and reassuringly not just based on BMI. There will of course be times where it could be detrimental and unsafe to do exercise/movement. It is therefore vital that every patient is treated as an individual and thorough assessment and clinical reasoning must be carried out within the Multidisciplinary team. Evidence also shows the importance of including Psychoeducation alongside exercise practice. It is also important to help patients understand more about the relationship they have with exercise/physical activity and to develop a healthier and positive one with both. It is also important to include the treatment of dysfunctional exercise eg using CBT. It is also recommended to have Specialist Physiotherapists integrated within the Multi-Disciplinary team. We have referenced the guidance provided by SEES: Safe Exercise at Every Stage which is a useful resource for clinicians alongside assessment and clinical reasoning.
	DS	"Many patients with EDs prefer definitions of recovery which focus on quality of life"	Agreed that a holistic consideration of quality of life markers need to be considered and reference to the input from the wider MDT, including OT and art/drama therapy, will be

		As an occupational therapist working in an eating disorders unit, it struck me that the SIGN guidelines make very little mention of Occupational Therapy as a treatment for ED, despite mentioning at various points about the importance of quality of life. Quality of life and meaningful occupation are the drivers behind occupational therapy. Often our ED patients are consumed by their disorder, having been cut off from social activities, employment, hobbies and even family and friends. They often don't know what they like and dislike and require support and expertise to explore this area in order to allow them to have some quality of life. I am acutely aware that there is very little evidence base (in order to back up a guideline) due to lack of research in this area - possibly due to the lack of OTs employed in ED services. There are only a handful of us in Scotland. This has changed very little in the years that I have been qualified. Despite this there are some interesting articles out there and they may be worth reviewing referring to in the guidelines. Perhaps including with the following section: Patients may relapse after functional recovery if the recovery was dependent on one main support, such as therapy or medication. Care plans therefore need to take a holistic approach to ensure patients are equipped to maintain recovery. Engage in discussions about returning to activities stopped during treatment, eg exercise. Life after treatment, and life after an eating disorder, should be considered.	incorporated into the guidelines. The evidence is lacking in these areas likely due to the small numbers of OT/drama/art therapists working in the ED field. This is a service development issue for all clinicians working in ED services. OT services play a vital role in managing transitions into and out of inpatient treatment; prevention of admissions; expedite discharges from inpatient treatment. A paragraph has been added to section 1.2.1 to stress the importance of other therapies, and explaining that there is a lack of evidence at the moment. A specific research recommendation has been added to section 18.2.
	LS	This section is appropriately balanced in reflecting what recovery means. In CAMHS this is something that can at times be harder to quantify due to parents seeking more psychological support and the young person not wanting to. Supporting discharge to practise life outwith of treatment is often hard for clinicians, who often share the concern around maintaining recovery.	Thank you, comments noted.
	DC	Good that this section does not just concentrate on weight - the emphasis on family based treatment was very much	Thank you for your feedback.

		on weight restoration and everything else gets better which is not the case for all and my daughter could this distressing Sections on refeeding and exercise helpful Acknowledging different treatments also helpful - some need a different approach - my daughter had FBT then CBTE and both were ultimately helpful Section on follow up helpful - we were discharged - I think the relapse advice and life after treatment really important.	
	PC	Important part of the journey of care. The re-feeding and maintaining nutrition section is vital. However, 3.3 does highlight one significant concern I do have about the draft guideline. Though MDTs and CMHTs are mentioned, there is little or no reference to some specialists in this field and how they can practice in an evidence based way-I would include Dietetics and Occupational therapy in this regard, both of which do have published evidence in eating disorder treatment. Certainly in work I am involved in both disciplines are often valuable, often even central, to good outcomes in a multidisciplinary approach. The other sub-sections are all completely merited , so this is not to detract from the valuable evidence gathered in the guideline around this area. One small potential amendment is that I did wonder if "refeeding is a useful intervention to prevent death" maybe undersells its importance somewhat. The section on comorbidities otherwise I think needs more referencing, it makes some statements that are true e.g. top page 11 ..."evidence base in the treatment of comorbidities that have been shown to interfere with treatment outcomes..." , would benefit from this. Minor amendments: 3.3.4 End first paragraph does not read well, looks like a typo.	Agree, however, the evidence on recovery and relapse prevention did not consider who was delivering the care. An MDT approach is generally advised for all ED services. Reworded to say refeeding is necessary. There was little evidence on comorbidities, but we felt it was important to include a section to highlight the importance of taking them into consideration. The section draws on the studies discussed within the sections on psychological therapies. Typo amended.

3.3.1	EM	Because of the wide range of expertise, it would be helpful to also have something as in NICE: "helping people to reach a healthy body weight is a key goal and weight gain is key in supporting other psychological, physical and quality of life changes that are needed for improvement or recovery." Where you write "An alternative explanation could also be that patients who can tolerate a higher weight at the end of treatment lose weight less rapidly and, therefore have a better prognosis, independent of the actual weight gain achieved. The current studies do not allow this to be defined further." I suggest you just write that there may be alternative explanations as causality hasn't been established. There really are quite a few possible explanations, and I'm worried that by writing just one, people will lose the opportunity of discussing and problem-solving.	The section reports the evidence which states that weight is associated with a lower rate of relapse. This statement has been removed.
	AH	Consider those with co-morbid ASD may require adaptions to the refeeding treatment plan due to challenges with flavours, consistency of products.	Other individuals may require adaptations, eg vegans. We hope an individual approach is taken for all. A good practice point has been added to stress the importance of taking dietary preferences, sensory sensitivities and cultural beliefs into account.
	HB	'Acute refeeding': I can imagine that from a patient perspective this might read as rather harsh and jarring. Is there a way to emphasize in the recommendation the 'holistic assessment' more?	We think this has to be acute refeeding for clarity.
	AT	2nd paragraph notes refeeding is useful, consider change that word to sometimes necessary. It’s a pretty powerful approach so would want something mentioned about safeguards. The recommendation wording to say it is offered routinely seems at odds with this section. It seems like quite an extreme option to be suggesting routinely offered. This section does seem to indicate how necessary refeeding is but the terminology doesn’t match 3.3.2 We were not aware of specialist physios in mental disorder and are unsure how rare these are, not sure how relevant	Refeeding may mean increase in food consumption and does not only apply to the use of enteral tube feeding. The sentence has been changed to say ‘refeeding is a necessary intervention’. Physiotherapists are part of the MDT within some inpatient services. There is a definite service development need to further develop the role of physiotherapy and OT in community services.

		this recommendation is if there aren't any in Scotland. Maybe the guidance should flag up the need for the development of these posts to support individuals with mental disorder?	
	AMc	"Makes refeeding a difficult treatment" I prefer to use nutritional rehabilitation / improving nourishment so as to not confuse with the re-feeding syndrome. It also sounds more compassionate to those terrified of weight gain. Is an ED a disease or a disorder?	This will be borne in mind in the patient version of the document. Changed to 'disorder' for consistency with the rest of the document.
3.3.2	EM	Regarding exercise, thank you Sandra Philip-Rafferty for bringing in SEES.	No action required.
	HB	Inclusion and recommendations are much needed on this topic. There is scope to include even more info. Focus seems to be greatly on AN.	The section reflects the available evidence.
	AT	This section addresses something that is done covertly into something that can be planned for and managed more effectively	Thank you for the comment. No change to the draft required.
	KBr	It is extremely positive that exercise management be recognised in this guidance. On reading the guidance I wondered if I could just comment on terminology used. Over the years there have been various and often interchangeable terms used to describe exercise associated with an eating disorder. However, these all mean slightly different exercise behaviours and links with the eating disorder. These are mentioned in the document, for example over-exercise, compulsive exercise and dysfunctional exercise. I wondered if there was any information within your references that supported the use of the new more overarching term of dysfunctional exercise? This is the term that the SEES guidance are now using, and I wondered if it might be considered to use this as standard throughout the document, or if the individual terms used needed to be those specific to the individual research being referenced?	We have retained the terminology used in the studies, but use 'dysfunctional exercise' in the recommendation.

		o My understanding is that the SEES guidance document outlines that it can be used to guide practise but does not replace specialist assessment and clinical reasoning. Within recommendation point 2 – the management of exercise needs to be considered by the MDT but also I wonder if the recommendation would be to be led by medical professional or exercise professional to reiterate this point from SEES? o Both SEES and LEAP guidance/documents recognise the importance of addressing physical activity and exercise and within eating disorders it is extremely important to be supporting a healthy approach to both physical activity and exercise. Has there been consideration for the inclusion of the term physical activity in the 'physical exercise' section title? o I noted the reference to the Female Athlete Triad in relation to athletes and sports – a more recent term used is REDS (Relative Energy Deficiency in Sport') – was there any consideration of this term in the literature instead of the Female Athlete Triad due to its very close link with eating disorders?	The sentence, 'It can be used to guide practice but does not replace specialist assessment and clinical reasoning' has been added. The sentence 'Assessment and supervision should ideally be carried out by a suitably qualified clinician such as a Specialist Physiotherapist in Eating Disorders.' Has been added as a good practice point. Title amended to include activity. REDS has been added to the good practice point. No robust evidence was found on this term.
	LS	Section refers to guidance for exercise within the adult population. It is something that within our CAMHS IPU would be helpful to consider in relation to physiotherapy access. What are the recommendations around under 18's? Absolutely paramount to include a section on sports in relation to hidden ED's. Loss of periods in females often tolerated and education/public information around this should be part of increasing awareness. Clinicians also need to be supported in supervision/cpd sessions to openly discuss the risks of returning to exercise with families.	Resource for Specialist Physiotherapists in Eating Disorders has to date been very limited. In a UK wide professional network and there are only 14 of us with the majority only allocated a few hours to a service and not integrated within the MDT. There are two Physiotherapists in the group working in CAMHS. There needs to by full assessment of each individual patient, more training/supervision for teams and integration of dysfunctional exercise and activity management as part of family work. There is at present little evidence for exercise intervention in young people. A Safe Exercise at Every Stage Guideline is currently being developed for children and adolescents. Reference to this has been added.
3.3.3	AT	Light on detail, given the data presented. Could more be said here about "specialist" input; there's mention of the assertive outreach but nothing about assessment and	Unfortunately the evidence identified in this area was light on detail so we were unable to add more.

		treatment options? Would be good to have a recommendation here about transition/transfer or joint working with the specialist or CMH teams.	The principles of systemic working including partnership working with general mental health services are particularly important in this patient group, in some cases there will also be transitions to be sensitively managed (see section 3.5) has been added.
3.3.4	GA	Typo: Line 5. Four of which WERE in patients with ED	Amended.
	AH	Patients with Co-morbid ASD may require a longer follow up plan and also many find talking on the telephone very challenging and therefore avoid or not answer calls. Clinicians must ensure the patient has a choice in the type of communication and given clear explanation of what each follow up call will entail.	Agree it is important that there is an individualised approach for all patients. The sentence has been changed to say individualised and holistic.
	SG	These are essential 'check in' components which I'd like to see as recommendations rather than good practice as in my experience these are critical to maintaining and guiding recovery.	These are good practice points because there is no, and unlikely to ever be, an evidence base to support them, but the guideline group considered to be important issues.
	AMc	1st paragraph last sentence we should be changed to were.	Amended.
3.4	AG	No issues.	Thank you.
	AR	May be necessary at times	No change to draft required.
	AGe	No issues	No change to draft required.
	EM	Maybe not the right place but... Should the guidelines include a reference to recommended practices for Nasogastric tube feeding under restraint: Fuller, S.J., Philpot, U & Working Group (2020) The development of consensus-based guidelines for dietetic practice in nasogastric tube feeding under restraint for patients with anorexia nervosa using a modified Delphi process. J Hum Nutr Diet. 33, 287– 294 https://doi.org/10.1111/jhn.12731	This is covered in the MARSIPAN guideline, cited in section 3.3.1.
	KB	Love the concept of "transition manager". Very helpful to explicitly state "of any age". I think it is a very wise choice to frame the use of the act as a "duty/responsibility" - both in terms of supporting AMPs to use the act when	Thank you.

		appropriate, and in discouraging the perception that not using the act is the "default" choice.	
	FB	Agreed, but again this requires sufficient trained professionals to achieve.	Comments noted. This is a consideration for implementation.
	HB	Is there scope to change the first sentence, any statement starting with 'The nature of eating disorders is ...' seems to be very ambitious, to say the least.	The section has been revised and the sentence removed.
	AT	In general we found this section to be quite limited with a number of inaccuracies or misrepresentations and no discussion of SIDMA. We highlight in yellow below the wording that concern us. Annex 1 Section 23 asks what are the risks and benefits of implementing the Mental Health Act for people with anorexia. We don't think the guidelines covers these in section 3.4 'Using the MHA to frame patient care' is less comprehensive it seems from what the guideline says it set out to cover. The nature of eating disorders is that weight loss feels like a positive solution rather than a problem. The vast majority of patients nevertheless manage to learn other ways to cope. Sometimes the illness is simply too severe to allow this. The European Human Rights Act makes the right to life and health even more important than the right to choice in these matters. UK jurisdictions, including Scotland, therefore have protective legal codes to ensure that patients get the care they need, even when they are unable to give full consent. The Mental Health (Care & Treatment) (Scotland) Act 2003 is used to make clinicians responsible for delivering treatment on a compulsory basis, either in the community or more usually in hospital. Eating disorders are explicitly defined as mental disorders in terms of the Act, and nutrition has the statement of treatment for the disorder.. The Act applies to all capacitous adults and children. The Mental Welfare Commission and mental health tribunals provide	The section has been revised following discussion with AT and other colleagues at the Mental Welfare Commission.

		monitoring and scrutiny to ensure the Act is used with compassion and justice, and to protect against stigma. MWC are happy for the guidance team to contact us to discuss the wording of this section.	
	LS	As a clinician we are often left to wait until further deterioration before admission and use of the mental health act are implemented. This can feel counterproductive, as its sends very unhelpful messages to the yp and family - you need to be sicker! Whilst we know that the more unwell the young person becomes, it becomes harder and takes longer to become more stable. I wonder about consistency of the use of the act with yps with EDs and the debate around capacity that often serves as a reason not to detain.	Thank you for your comments. No change to the draft required.
	DC	Very clear	Thank you.
	PC	Maybe a reference to CPA be included here or in transitions section-again is some published material on that.	The Care Program Approach didn't feature in the evidence or guidance identified to answer either the transitions or the Mental Health Act section.
3.5	AG	No issues.	Thank you.
	AR	Can be difficult and needs to be managed appropriately	Agree. No change to draft required.
	EL	There is a Scottish Government Transition Care Plan which could be included to support improved transition between CAMHS and AMHS on the HIS website; http://www.healthcareimprovementscotland.org/our_work/mental_health/transition_care_plans.aspx	The Scottish Government guidance on transitions from CAMHS to adult services has been added to the guideline. However, The Royal College of Psychiatrists guidance is specific to Eating Disorders, and is guidance for any transition, not only from CAMHS.
	AGe	Clear and adequate	Thank you.
	AL	It is vital if this guidance is to lead to improved care and support that there is explicit inclusion of input into services from Music, Art and Drama therapists	Please see response to FH comment on p10.
	MMac	Rather than increasing age of transition or having all age services, more flexibility re timing of transition on an individual basis. Transition co-ordinator rather than	No evidence was identified to recommend one timepoint for transition over another. This was also noted in the Royal College of Psychiatry report.

		manager may be better terminology	Terminology changed to Transition Co-ordinator.
	KB	Admittedly this is a very inpatient-CAMHS-centric concern, but I think there has to be a distinction between inpatient and community care when talking of flexible transition age. IPU beds are proportionately far more scarce than outpatient appointments. I have personally struggled to move inpatients to adult services partly due to ambiguity about this. On occasion this has led to reduced bed availability and in turn admission of other, younger, YP to inappropriate settings. I am more than happy to discuss this further.	This is a good point, however, no evidence is currently available to allow recommendations addressing this issue.
	GV	Essential and good recommendations made, AN does emotionally delay the patient so Although they may be 18, emotionally they will be younger and this should be given weighted	Thank you. No change to the draft required.
	FB	I do not like the wording on the qualitative studies "One found that denial, coupled with ambivalence to weight restoration, interfered with transition" I would personally describe the state of the patient's "motivation" to be more likely to be the result of anosognosia than of "denial". The lack of available treatment options, and the sudden transfer of full responsibility to engage with any services that are available from caregiver to, often very unwell, patient is also a factor. I have experience of transition from out of area inpatient care to local community care being very poorly managed (by everyone including me as the carer) because of completely different views on diagnosis and treatment between the two teams involved	The group would agree, and consider the wording that you have suggested more appropriate. However, as this is a direct quote from the study, this does not allow for change. The guideline does include recommendations for alternative treatment options that currently have an evidence base which is the objective of guidelines. Implementation of treatments within guidelines would be decided by individual health boards.
	AH	Best practice - all Autistic patients must have extra considerations given during any transitions. Change is extremely anxiety provoking for Autistic people and even a small change e.g. moving from one room to another can cause the patient to withdraw or avoid. Staff should be aware of the challenges for Autistic patients during periods of both small and larger transitions.	This is a good point made about the difficulties of Autistic patients, however, no evidence is available relating to transitions. A reference to the PEACE Pathways has been added to the introduction to the guideline to offer further expert opinion-based advice for autistic patients.

	HC	It must be recognised that not all patients will have a supportive family to help them through transitions. GPs need to be equipped with the basic skills and knowledge of services in their area. Collaboration between adolescent and adult services ACROSS REGIONS is essential.	Unfortunately no study differentiates between patients with or without supportive families. However, the guideline does include the importance of collaboration between services.
	CV	Some clarity in the recommendation might be useful on whether the recommendation re transitions managers is based on evidence of this being one of the clinicians already working with a family or who will be from the next service, or any staff member with a specific role of transition manager? would it be useful to be explicit or some mention when it discusses good links between services of how this is attempted between not only within health boards. From experience transitions between health board have been harder to plan, get info on, to follow up etc. many adult services suggest therapy breaks between ED treatment in CAMHS and ED treatment in adult services - often making follow up by the referring clinicians harder or young person not engaged in new service/staff before commencing that 'break'. if there was any, it would be helpful to have outlined if there was any evidence /benefit or not for this practice in ED transitions research.	Unfortunately, no good-quality evidence was identified to make more detailed recommendations. The recommendations provided are taken from the Royal College of Psychiatrists guidance and cover all transitions including different boards and patients of all ages. This has been made clearer in the guideline.
	HB	The section on 'Transition' is very clear. The bullet points help greatly. There is scope to say more (include research on effectiveness) of a 'transition manager'.	Thank you for your comments.
	DW	We welcome the recommendations that address some of the serious issues experienced by young people moving from child to adult services and the real fear that parents express and the need for more specialist transition services support.	Thank you for your comments.
	EB	Transition recommendations are too vague – “several months” and no timescale or details on the last one Transitions – need to reinforce that care should always be developmentally appropriate and recognition that young people with EDs can be developmentally delayed, due to	Unfortunately there is no evidence within transition studies that met SIGN criteria that identifies a specific timescale for when to start transitions. A good practice point has been added:

		biology and also missing out on normal teenage life.	Clinicians should remember that serious illness in childhood and adolescence often causes people to miss out on the psychosocial and even physical progress enjoyed by their healthy peers, and can delay their ability to function independently from the support of family and other carers. Family involvement may be beneficial beyond the usual age where this seems appropriate.
	JMc	Definitely agree that there needs to be better/easier transition. Getting access to adult therapy is difficult and the type of therapy that is offered is a lot different, so perhaps a shift in focus towards the end of CAMHS treatment would set the patient up for this better? Recommendation about written plan for patients moving from one service to another seems like a great idea, having a better insight into the future of your care/support would be great as a lot of extra stress comes from not knowing what will happen once the primary care you receive stops.	Thank you for the suggestion, it is a good point, but unfortunately, no evidence considered this.
	AT	It would be helpful to establish how the “transition manager” would be identified and agreed upon.	There was no evidence to guide this.
	DS	I'm aware that not everything can be covered in this section, but it may be helpful to raise awareness that there is often difficulty for patients transitioning between in patient and out patient services, particularly given the average length of hospital stay for our patients being around 3 months, longer with the current pandemic. Our patients struggle moving from 24hour support to much less in the community and it would be useful to look at research around a more stepped approach such as in patient to day unit and community support - which is offered in some areas.	There was no specific evidence on this but the RCP guidance covers all transitions, and this has been made clearer in the draft.
	LS	Highly important aspect of CAMHS work. Paediatric colleagues are requesting more information and training on EDs. NHS Lothian have a good adult/CAMHS transtion protocol in place. Significant challenges are around the	Thank you for sharing NHS Lothian’s recognition of need, and successes in implementing a transition protocol. Your point concerning the lack of guidance between different therapies delivered by services is a valid one, but unfortunately no

		different treatment recommendations in CAMHS compared to adult. The transition of parental support and how as clinicians we start that work/conversation early enough. At present this is 6 months prior to 18th birthday, 1 year is a really complex case. More guidance is perhaps required around aligning therapy approaches as best as possible. Quite stark differences in level of risk that Adult colleagues work with compared with CAMHS. Treatment approaches are also drastically different.	evidence is available to provide guidance at this time by means of recommendations within this guideline.
	SG	This can be a really challenging time so continuity of care and patient centric approach rather than one size fits all is essential. Involvement of parents and carers in plans and discussions during and after transition is also essential as without this the young person can feel suddenly they are entirely responsible for everything to do with their continued care. This can leave them over burdened and ill equipped to manage their illness and determine the support they need potentially leading to an increase in the likelihood of disengaging from treatment through lack of understanding or feeling overwhelmed. I like the idea of the checklist as part of the documented transition plan and the potential flexibility to delay transition to 25 years of age.	Thank you for your thoughts, and support for the recommendation of transition planning and sharing your liking for one of the alternative suggestions currently being suggested of the age of transition to be 25. This suggestion within the qualitative research is one of a number of suggestions, and no studies are currently available that provide evidence of benefit of a particular suggestion to enable SIGN to make a recommendation based upon the suggestions.
	DC	Well written. FBT emphasized role as parents in feeding them at transition they have no role acknowledged although in reality do in practical terms Transition often non existent as criteria for accepting patients different. This may also be at a stressful time for sufferers as they may be leaving home for the first time etc If this guidance is followed it will really improve support	Thank you for highlighting some of the issues you are aware of within the transition process, and for supporting the recommendations being made.
	AMc	Transition 4th paragraph Some services are all age services. There are benefits in this that young people do not need to transition. Also there have been discussions that adolescence goes on past 18 and CAMHS should work with young people into their 20's. There would need to be a lot of organisational change to	The alternative suggestions as to different ways services can be structured has been included within the body of evidence. It is noted that these are suggestions, and no evidence is available supporting the development of services by one alternative or another. As SIGN guidelines are based upon evidence it is unable to make a recommendation in this instance.

		accommodate this however if it was in the best interest of patients it should be looked at. Do SIGN want to comment on this at all? And the maintenance of some element of external monitoring after transfer to …. I am unclear what this means.	The study this has been quoted from stated that this was by GP's, so by primary care has been added to the sentence.
	PC	Important section to include as has been neglected in the past with respect to the journey of care.	Thank you.
4.1	AG	No issues.	No action required.
	AR	Follows the literature	No action required.
	AGe	Good, including video conferencing is a good idea	No action required.
	AL	It is vital if this guidance is to lead to improved care and support that there is explicit inclusion of input into services from Music, Art and Drama therapists	Please see response to FH comment on p10.
	KB	I agree with the importance of full explanation of therapy. Often I have encountered YPs unaware of undergoing therapy at all, let alone what type and purpose!	Comment noted, thank you. No change to the draft required.
	FB	Treatment plans should also, where at all possible, be discussed with carers AND with the multi-disciplinary team around the patient (which realistically given the resources available to most patients may just be the GP and an employer/social worker/college support officer) In order to provide useful support those around the patient need to know what is going on. It is not a breach of confidentiality to welcome others to provide support, it is a sometimes intolerable burden to expect, by default, the patient to be the go-between between themselves and their clinicians.	We think the comment refers to an overall care plan which would be discussed with relevant carers and supporters with the patient's permission, However, for therapeutic interventions there is an assumed confidentiality in the discussions between patient and therapist.
	EB	Would be good if this section could reference the importance of therapists reflecting on their own personality traits and emotions can lead to tendency to avoid the more challenging aspects of therapeutic models and how clinicians can stay alert to and address this - https://pubmed.ncbi.nlm.nih.gov/26752326/	This is something that should be mitigated by ongoing training and supervision, as recommended in the good practice point.

	LS	Access to and job planned supervision is essential in delivering on model and effective treatment.	Supervision in included in the good practice point.
	SG	I would like to see these as recommendations. Often the patient is unaware of the support that is available; what each intervention is useful for; and what might be helpful for them, so a conversation between the professional and the individual sharing the options available and their uses and a discussion about which intervention might work best is essential to engagement with treatment options. All professionals involved in the care of people with eating disorders should have specialised training before working in this field as a lack of experience or understanding of eating disorders can have a significantly negative impact on the individual. Ongoing training and supervision is also essential. Professional quality monitoring and patient feedback should be proactively managed in all cases and where this is not in place should be introduced to drive efficacy of treatment and quality of professional support as well as accountability for outcomes in therapy.	We agree with these points, however, the statements are good practice rather than evidence based.
	DC	Importance of outcomes being different for sufferer and clinician highlighted	Thank you.
	PC	Are there any references for this?-I do agree, but left curious.	The text refers to the guideline development group's reflections on the evidence review for sections 5–12, and the issues discussed in sections 1.2.3 and 3.3. The good practice point and information points are based on the guideline development group's experience of what constitutes best practice, in areas that are unlikely to ever have studies undertaken to support them.
4.2	AG	No issues.	Thank you.
	AR	These have been tried for at least a couple of decades	Comment noted.
	AGe	Excellent idea, including barriers to remote approach would be beneficial	Thank you.
	AL	It is vital if this guidance is to lead to improved care and support that there is explicit inclusion of input into services from Music, Art and Drama therapists	Please see response to FH comment on p10.

	MMac	Delivery of therapies remotely acts as an adjunct to F2F but in most cases should not replace.	The good practice point takes this into consideration, stating that videoconferencing 'could be offered'.
	KB	Also non-inferiority studies in other disorders with YP with ASD.	The search parameters were restricted to eating disorders therapies.
	FB	I think delivering therapies remotely is a real benefit to patients and providers. However physical face to face monitoring will still be needed - you can't take a blood test remotely	Comments noted. The good practice point states this could be offered. It is an option where there may be barriers to meeting face to face.
	AH	Many autistic adults have reported finding online sessions preferable due to being in more control over their environment. However others find the confusion of seeing the clinicians on screen very off putting and can interfere with therapy. Choice is essential	The good practice point suggests it can be offered as an alternative to face to face, so patients could be given the choice.
	HB	Emphasis here is on 'similarity'. Are there reported downsides to delivering therapies remotely? Are there reported advantages/	Advantages and disadvantages can vary depending on the individual's circumstances and preferences. This section is to establish that it is feasible and can have similar clinical results to in-person therapy.
	AT	There's reference to a study which showed improvement in take up/starting point in the FREED study in 3.2 about early engagement phone calls. Could there be something in a recommendation for the delivering psychological therapies remotely, in that there's scope to do this more quickly? The word "alternative; could the word "adjunct" be used instead.	A sentence about the FREED model using phone calls for early intervention has been added. Adjunct has been added, but we would prefer to retain 'alternative' as for some people or in some circumstances (eg remote location, pandemic) this may be the only option.
	LS	Recognition of the limitations that this may bring and how it can be exploited by the tricks of the ED. Therefore supporting staff to risk assess appropriately and review progress.	Agree, but this is also the same for in-person therapy.
	SG	Video conferencing should be considered as a standard option.	The GPP has been changed to say it could be considered as an alternative or an adjunct. There is not sufficient evidence yet to state that it should be a standard option.
	DC	Good I have used remote access for paediatric consultation - I'm not sure how this works for non engaging teenagers but	Thank you. Comment noted.

		good for carers	
	PC	This evidence base has some limitations in defining fully where there are or could be problems with remote delivery, particularly with respect to the issue of digital exclusion in my opinion. Maybe potential drawbacks/problems to be aware of for some need to be outlined a little further in this guideline at this point or later.	This is only being recommended as something to be considered as an option. It is hoped that further robust evidence will be published following the increase in use during the pandemic.
5.1	AG	No issues. Good use of evidence to hand. Thoroughly researched	Thank you.
	AGe	Explained clearly	Thank you.
	BC	Speech and Language Therapists play a key role in adapting treatments like CBT-E so that it can be accessed by children and young people with comorbidities like AN. We know children and young people where ASD and AN are co-morbid are more treatment resistant and need support to participate in treatments where they are required to reflect on and discuss their thoughts and feelings. I think the SIGN recommendations should include a recommendation that augmentative Speech and Language Therapy approaches should be considered in adapting (CBT-E) where ASD and AN are comorbid or where there is a high level of ASD traits	A multidisciplinary approach is needed, however the guideline focused on areas where there is an evidence base. A paragraph has been added to section 1.2.1, and a call for research has been made in section 18.2.
	AL	It is vital if this guidance is to lead to improved care and support that there is explicit inclusion of input into services from Music, Art and Drama therapists	Please see response to FH comment on p10.
	KB	Helpful to point out comorbidities that affect choice of therapy model. I was unaware of the OCD-Systemic therapy link!	Thank you. No change required.
	EM	This section is, according to 5.1, for under-18s. I welcome the recommendation for FBT first. Please would you add a recognition that this recommendation is just as valid, in terms of evidence, with an 18-year old, since I think all the studies you quote went up to and including 18 years. I understand that because the NHS is set up to move 18 year olds to another service, you don't want to list FBT just	A paragraph has been added to the definitions in section 1.2.3 to explain that the terms are used colloquially, rather than as specific cut off points. Age ranges included in studies have been added to sections 5 and 6.

		for that age. However we can seriously hope that over time, there will be a lot more flexibility around ages, and possibly there will be therapists in "adult" services who are totally competent at FBT. Surely then, FBT should be high on the list of choices for an 18 year old, again, given the scientific evidence. On another point: I see that you did not put Adolescent-Focused therapy in the recommendations, whereas NICE assessed it was good enough as a second choice, equal with CBT-for-eating disorders. I just want to make sure you are absolutely certain about this. When I wrote about AFT for my website and checked it with James Lock, he was clear that it could be a useful tool in the toolbox -- and this is from someone who has brought FBT to all of us.	Only one RCT on AFT was identified and it did not have results that showed sufficient efficacy to support a recommendation.
	FB	Cynically I assume that the rejection of AFT which is included in the NICE guidelines comes as a result of studies showing that it leads to more hospitalisation than other treatments. This may be fine if you are James Lock working from two hospitals but less than ideal if you are in the UK where there are currently no specialist inpatient beds available in the whole country. I do think that the structure of care does need to be considered and that inpatient treatment is always going to be needed. It shouldn't only be considered when "families fail" either - early intervention with a brief admission might be an option for some.	Due to big variation in thresholds and practice around admission of children and adolescents with eating disorders to hospital it is difficult to make international judgements about thresholds and admission rates to paediatric and psychiatric hospitalisation. AFT is based on a single group of patients and the follow up study. CBT-E has a greater volume of research studies to support its use.
	FH	Art Therapy has been offered as a psychological therapy for treating patients with an eating disorder in REH for the past 20 years. Recently we have been using Art Therapy with an MBT informed approach for ED patients. It can be a first line intervention for children and adults with any eating disorder, including a psychoeducational component.	See response to FH comment on p10.
	SY	No mention of the Arts Therapies for children and YP's. There is evidence that these are helpful to patients. The	See response to FH comment on p10.

		British Association of Art Therapists, BAAT, have gathered a number of papers on efficacy to be submitted to this survey.	
	HB	It is very important to have gaps in research being pointed out here.	Agree. Research recommendations are listed in section 18.2.
	JMc	Again, I would say that from experience FBT worked best for me. The combination of having familiar people with me for the initial visits helping to calm me down and further along the line them being able to learn more about my own struggles and how to deal with the problems that came up along the way. I would say that adding in CBT-e towards the end of the patients journey is helpful though. I think that this is where I got most insight into life after/without the eating disorder which, personally, I would say is one of the most important parts about recovery since the person can get very much wrapped up in the ED and their identity/outlook on life is limited to their disorder, so help looking past this is key.	Thank you for your comment. No change to draft required.
	LS	Investment in access to training, CPD slots and supervision critical.	This is addressed in section 4.1, Treatment fidelity.
	SG	Consistency of approach and availability of adequately trained professionals is essential	This is addressed in section 4.1, Treatment fidelity.
	DC	Well written and helpful to see evidence We experienced FBT and CBTE Good for families to know that different approaches can be helpful	Thank you.
	PC	The evidence base looks well researched here.	Thank you.
5.1.1	CV	5.1.1 -5.1.5 has lots of information and text - could it be worth highlighting /bolding the key messages/findings? ED or OC symptom severity - is the OC worth explaining the acronym as not all readers would easily know/guess this one.	The recommendations are listed in their own section at the end of the evidence review. This is consistent with the other sections on psychological interventions, so that all the recommendations on psychological therapies for each patient group can be seen together. This has been changed to Obsessive Compulsive. The acronym OCD is used and explained in section 1.2 of the

			guideline, and in the list of abbreviations.
5.1.2	CV	Enhanced cognitive behavioural therapy (CBT-E) - is this referring to Fairburn model or meaning more general any transdiagnostic CBT for EDs? would it be useful to state this as more often enhanced can be implied to be fairburn and CBT-ED waller? It reads currently Those who competed treatment - is this meant to say completed treatment? For all the CBT-E literature/evidence is this CBT as stand alone/as first line in those trials or adjunct eg after a family based intervention had been tried - if known would be useful to have in the summaries here.	This has been clarified to state that it is Fairburn's model. Yes, amended to completed. It is unclear from the studies. In two studies one of the exclusion criteria was treatment in the past year, the other did not stipulate.
5.1.4	CV	Goes into detail on CBT-E study on impact on weight gain in kgs and numbers drop out, not respond to treatment etc - would it be useful to see same detail for 5.1.1 in sentence that just states suggests family therapy may be more effective than other treatments on rates of remission and on weight gain.72,73.	The first sentence is an introduction, and gives the overarching conclusions of multiple studies in two systematic reviews. Further details from particular studies follow that.
5.1.6	CV	Recommendations for psychological therapies Would be worth adding wording like First-Line? this has been used in other parts of the guideline, for the R - Family Based Treatment should be offered to young people with restricting eating disorders. Enhanced cognitive behavioural therapy (CBT-E), at a dosage of 20–40 weeks, could be offered to adolescents with anorexia nervosa. - as stand alone and or adjunctive could be useful depending on what is meant here in this recommendation - otherwise at present all 3 feel like given same weighting or in any order in way written in the 3 R's here. No mention of MFT as a R or additional comment but in	First line has been added for FBT and second line for CBT-E.

		5.1.1. it stated "A multi-family therapy approach (MFT), in addition to FBT as a supplementary or standalone treatment, had superior end-of-treatment outcomes compared with those without MFT"	The MFT study has been reviewed and the wording changed in 5.1.1. The recommendation remains the same, and MFT should be considered as one of the augmentative approaches that could be considered to maximise outcomes
5.2	AG	No issues. Good use of evidence to hand. Thoroughly researched	Thank you.
	EM	Can you be clearer that there's no evidence for Fluoxetine in treating EDs. I understand you are including it for comorbids, but is there not an issue that it is ineffective when there has been great weight loss?	The first sentence has been changed to: Evidence on the use of antidepressants (including fluoxetine) in adolescents with AN was of poor quality.
	KB	This is excellent. Explicit statement of lack of evidence or evidence of lack of benefit is so important. It will hopefully impact on over-prescribing.	No action required.
	FB	Any prescribing for the CAMHS age group requires a psychiatrist. I believe there is currently a crisis in recruitment, although I am not sure whether this is the case in Scotland	Who prescribes is an implementation issue and outside the remit of the guideline.
	CV	Psychotropic medication, most often olanzapine or fluoxetine, is commonly prescribed for children and young people with EDs, usually to mitigate specific behaviours such as uncontrolled exercise, or a comorbidity.85 does it need to state as it did for sentence above whether any reviews show effectiveness or not, despite stating commonly used?	This sentence has been changed to: Despite a lack of evidence, psychotropic medication, most often olanzapine or fluoxetine, is commonly prescribed for children and young people with EDs, usually to mitigate specific behaviours such as uncontrolled exercise, or a comorbidity.
	AT	Medication for AN in CYP: this section lacked detail (as little evidence) but made ref to fluoxetine/olanzapine sometimes prescribed to mitigate over-exercise in CYP, without further comment. We were not sure about mitigate specific behaviours such as uncontrolled exercise, or a comorbidity.85 the description is better in the section 9.5 about reducing distress and obsessionality, although the BMJ paper describes this use of olanzapine.	The sentence in section 5.2 is describing the findings of the survey on why psychiatrists prescribe to young people with ED, so we would prefer to leave this as it is.
	DC	Helpful Important to recognize comorbities - treating depression in	Thank you.

		my daughters case enabled her to make progress with ED too	
	PC	Likewise a good as summary as possible.	Thank you.
6.1	AG	No issues. Good use of evidence to hand. Thoroughly researched	Thank you.
	AGe	Recommendation are clear	Thank you.
	AL	It is vital if this guidance is to lead to improved care and support that there is explicit inclusion of input into services from Music, Art and Drama therapists	Please see response to FH comment on p10.
	KB	Why is CBT preferred over psychodynamic when the evidence discussed found them comparable? I'm no fan of psychodynamic therapy and could guess that dose or cost-effectiveness is the tie-breaker, but it should be obvious from the evidence why one intervention is preferred to another.	There is more evidence to support the use of CBT than psychodynamic therapy. Further robust trials into psychodynamic therapy are needed before it could be recommended as first line.
	CV	"Adolescents with bulimia nervosa could be offered either cognitive behavioural therapy or family-based treatment-bulimia nervosa as first-line treatment" - as the evidence outlined from the 3 adolescent specific studies in this section seemed to be more in favour of FBT or just more studies of FBT for adolescent specifically than CBT would it be useful to have FBT written before CBT as at present the recommendation seems to say CBT or FBT but by having CBT first? as one of the RCTs was CBT-A and not CBT-E this sections leaves me a little unclear to whether when it recommends CBT is it meaning CBT-E or CBT-A or both and in any order?	It is either/or. As different types of CBT were used in the studies we have not specified a type in the recommendation.
	SY	The Arts Therapies have not been mentioned as a treatment for children and YP's and I think this is an oversight of its valuable contribution in the treatment of people living with an eating disorder.	Please see response to FH comment on p.10.
	HB	Clearly written but there could be a comment on the emphasis of research on girls (and lack in boys?).	This is covered in sections 15 and 18.
	AT	Treatment for BN – evidence for therapies reported as	The 1++ reflects that the meta-analysis was well conducted.

		strong (1++), yet recommendation did not appear robust .Adolescents with bulimia nervosa could be offered either cognitive behavioural therapy or family-based treatment-bulimia nervosa as first-line treatment .there is lack of a broad statement saying psychological therapy “should” be offered for CYP with BN. “Should” is used elsewhere for recommendations with evidence of lesser reported quality (e.g. family based therapies for AN based on 2++ evidence)	The downgrading of the evidence is because it is based on adult studies as well as adolescents.
	LS	More investment needed perhaps due to this not being the most common ED in adolescence. More access to training essential.	These are issues for implementation.
	DC	Good	Thank you.
6.2	AG	No issues. Good use of evidence to hand. Thoroughly researched	Thank you.
	AGe	Recommendation are clear	Thank you.
	GA	The recommendation in 6.2 (and 10.4) do not align with the NICE guidance. This may cause confusion when patients (especially young people at university) move between England and Scotland. Reference to the NICE guidance could be considered to explain why this recommendation was chosen to aid clarity for clinicians	SIGN methodology was followed and may have examined a different group of papers. We included a large SR of papers on Bulimia Nervosa treatment Shapiro 2007 which was outwith the usual 10 year period for SIGN papers because it was felt that specific guidance on the use of medication was important as it is commonly considered.
	KB	One concern: "in combination with psychological therapy" - why? Was the evidence in 16-17 year olds only demonstrated in those also undergoing therapy? If not, the statement may be a barriers to YPs with BN that don't engage with therapy for some reason benefitting from SSRI. Could the statement say "along with the offer of psychological therapy" instead if this is the case?	Shapiro 2007 shows that medication alone did improve outcomes although associated with side effects, although Reas 2020 showed more benefit for combination of medication and psychological therapy. The recommendation has been reworded to: Fluoxetine 60mg may be considered in the treatment of patients with bulimia nervosa, aged 16-18, for short-term use along with the offer of psychological therapy, and with monitoring for suicidal, self-harming or aggressive behaviours, particularly at initiation.
	EB	CYP – BN Treatments – Recommendation wording could be clearer that medication alone is not acceptable treatment – it must be offered in combination with	Studies which included some adolescents did show benefit in the short term for medication alone (Shapiro 2007) The points and suggestion in the comment from KB above seems most

		psychological therapy – as in how they do it in the AN recommendation on page 24.	appropriate and the recommendation has been reworded accordingly.
	DC	Clear	Thank you.
7.1	AG	No issues. Good use of evidence to hand. Thoroughly researched	Thank you.
	AGe	Recommendation are clear	Thank you.
	AL	It is vital if this guidance is to lead to improved care and support that there is explicit inclusion of input into services from Music, Art and Drama therapists	Please see response to FH comments on p10.
	CV	When it refers to CBT interventions in this section it is clear no adolescent studies and based on adults but is the CBT evidence with adults and BED - for CBT self help, group or 1:1 and if this is clear should that be expanded as options when says R "Cognitive behavioural therapy, interpersonal psychotherapy or family-based interventions could be offered to adolescents with binge eating disorder"?	It is difficult to make explicit recommendations on the format of CBT delivery when there has been no RCT’s with children or adolescents therefore we have to keep this recommendation broad.
	SY	The Arts Therapies have not been mentioned as a treatment for children and YP's and I think this is an oversight of its valuable contribution in the treatment of people living with an eating disorder.	Please see response to FH comments on p10.
	HB	Could you highlight the obvious gaps in research here?	Research recommendations are covered in section 18.2.
	AT	Chapter 5 to 12 – these chapters are comprehensive, clear and well defined. Some of the recommendations are very clear, and state should, but in other cases less so e.g. chapter 7 for children with binge eating disorder it’s a “could”, when it’s preferable to have a “should” to make sure that something is offered.	The use of “could” and “should” is aligned with the strength of the underpinning research base to support options of treatment. Information on the strength of evidence is in the boilerplate of the guideline. The recommendation has been changed to: Either cognitive behavioural therapy, interpersonal psychotherapy or family-based interventions could be offered as first-line therapy for adolescents with binge eating disorder.
	LS	Reiterate the same points as with BN. Not enough awareness for diagnosis and treatment.	These are implementation issues.
	DC	Well written and helpful	Thank you.

7.2	AG	No issues. Good use of evidence to hand. Thoroughly researched	Thank you.
	AGe	Recommendation are clear	Thank you.
	CV	"Lisdexamfetamine (LDX) has been shown to reduce binge and purge behaviours and reduce BMI in people with BED" - if also had compensatory behaviours such as purging would they have BED? also does this slightly imply treatment in BED is to lead to weight loss/reduced BMI where as often that isn't the specific goal of treatment in BED to reduce weight or BMI - so this statement reads slightly uneasy w/o this context even though it does state later in this section that overall meds not recommended.	Agree this is confusing. The paragraph has been removed.
	PC	End 2nd paragraph here slightly confusing, not entirely sure what is being referred to in terms of adults-LDX or any pharmacological treatments?	The first paragraph on LDX has been removed, and the remaining paragraph has clarified that there is no evidence for pharmacological therapies specifically in children and young people, then refers to section 11.4 for evidence in adults.
General	AG	Appropriate and to the point.	Thank you.
	AR	Very helpful to give guidance	Thank you.
	AGe	Recommendation are clear	Thank you.
	KB	Information on prevalence and warning signs is helpful. I think the recommendation to use MHA to give insulin is controversial. On advice from MWC I used AWI to give insulin and MHA to give food and antidepressant treatment. Insulin is not a treatment for any mental disorder, and IDDM is not a sequelae of any mental disorder, so insulin arguably cannot be authorised by MHA.	Following further discussion with the Mental Welfare Commission, it was clarified that use of the MHA is appropriate. This has been incorporated into revisions to section 3.4, and, rather than including the good practice point in section 8, signposting to section 3.4 has been added.
	HB	Clearly written.	Thank you.
	AT	Type 1 diabetes: recommendation "The Mental Health Act should be invoked when necessary to oblige patients to accept insulin to save life or prevent irreversible damage." This is a complex medico/legal situation and we would ask the guidelines team to contact MWC to discuss the	Following further discussion with AT and colleagues at the Mental Welfare Commission, this issue has been resolved and explained in section 3.4.

		wording of this section.	
	LS	Closer links with Diabetes specialist teams required. Supporting training, resources, consultations and treatment.	The recommendation has been reworded to demonstrate that there needs to be combined input from diabetes and mental health specialists.
	DC	Important to highlight - as a paediatrician (not a diabetes specialist but I frequently see children with diabetes on the ward) I was not aware of there being such an increased incidence.	Thank you. No action required.
	RT	As one of the few inpatient consultants in ED in Scotland, I was very surprised and somewhat alarmed by the 'R' recommendation status here and some of the content - these are my concerns - the quality of the systematic reviews and RCTs are very poor with the majority of the studies rejected on quality - the conclusion of the main paper actually showed no effect on the interventions but a very spurious inferences was made saying 'probably inpatient v outpatient care is better with certain combinations of therapy ' - but this was very speculative - to then promote this research and translate it into a recommendation of inpatient care in a SEDU felt like a massive leap with no justification and has a massive resource implication for our service - this could be used to drive referrals and demand admissions - unless more robust evidence can be presented - this recommendation should be downgraded - we have no diagnostic symptom markers clearly defined for 'diabulimia' nor has there been any attempt to define the core psychopathology - there is very limited research . We still have not answered key questions eg, in what sense is diabulimia an eating disorder and not a personality disorder ? See below Personality Factors and Disordered Eating in Young Women with Type 1 Diabetes Mellitus	The wording of the recommendation has been amended to show that only some patients would benefit from inpatient care in SEDU and to show that the evidence base is weak.

		February 2005Psychosomatics 46(1):11-8 DOI: 10.1176/appi.psy.46.1.11 SourcePubMed The recommendation for inpatient treatment is over certain in my mind. There is no evidence of harmful effects of hospital treatment. I would like much more clarity around the associated comments about using the Mental Health Act to compel patients to take insulin. This was equally alarming with no qualification of what that means in practice. Is the guideline saying that we should be advocating that psychiatric nurses should be given the power to restrain patients to deliver SC inulin even if they have a normal BMI? This requires very careful collaboration with the Mental Welfare Commission and cannot be part of a guideline without much more cross party consultation. I really feel alarmed by this statement.	Following discussion with the Mental Welfare Commission, this advice has been incorporated into section 3.4.
	AMc	"The management of insulin is used" Management could be changed to omission for clarity. To lose calories and avoid weight gain. Is it to avoid weight gain or to lose weight or both? This is associated with an elevated glycated haemoglobin. Insert elevated for clarity. HbA1c is The last sentence in this section "DKA admissions and elevated HbA1c" should there be a high or elevated in there?	Amended to omission. Both. Weight loss has been added. Elevated added. Elevated added.
	PC	Outline useful.	Thank you.
	MC	Pre- Diabetes (T2) Type 2 Diabetes does not appear to be included. This condition is far more common than T1 Diabetes. Binge eating disorders can seriously impact on glucose control	The guideline is focused on the omission of insulin rather than the management of diabetes as a result of an ED. The sections on BED should be helpful to those who develop Type 2 diabetes due to binge eating, along with guidelines specific to

		and lead to serious mental and physical health problems.	the prevention and management of diabetes. A paragraph has been added to the introduction of sect 8 to explain the focus is on the omission of insulin.
	SGF	Important to be aware of lower thresholds for ketoacidosis in non-white populations and in cultural settings like during religious fasting which can mask a disorder.	There is a higher risk of DKA in minority ethnic populations in type 2 diabetes, which is not covered by this guideline. Fasting ketosis does not lead to DKA - it is insulin omission in type 1 which leads to DKA.
8.1	AG	Psychological services, especially in adult diabetes are a somewhat variable feast and not always available.	We hope that the implementation of the recommendations in the guideline should help to address that.
	AJ	I am interested in the use of the Mental Health Act to oblige patients to accept insulin. I have had recent consultation with the advisors from the Mental Welfare Commission, around a specific case. I was clearly informed that insulin could not be given under the Mental Health Act, but rather under Adults with Incapacity Act. Is this something that could be clarified further please?	Following discussion with the Mental Welfare Commission we have clarified that insulin can be given under the Mental Health Act. This has been explained further in section 3.4, with signposting in section 8.
	AR	The research is at a fairly early stage say compared to AN	Agree. The need for further research is highlighted in section 18.2.
	AGe	Recommendation are clear	Thank you.
	AL	It is vital if this guidance is to lead to improved care and support that there is explicit inclusion of input into services from Music, Art and Drama therapists	Please see response to FH comment on p10.
	SY	The Arts Therapies have not been mentioned as a treatment for children and YP's and I think this is an oversight of its valuable contribution in the treatment of people living with an eating disorder.	Please see response to FH comment on p10.
	RN	'The Mental Health Act should be invoked when necessary to oblige patients to accept insulin to save life or prevent irreversible damage' Please consider re-wording this recommendation or to limit the recommendation to 'save life', in which case adults with incapacity act can be used. I have engaged with my own MCN lead in Lothian, and the recommendation to prevent irreversible damage is felt to be quite undefined.	Following discussion with the Mental Welfare Commission we have clarified that insulin can be given under the Mental Health Act. This has been explained further in section 3.4, with signposting in section 8.

		Outwith the context of a life threatening scenario, obliging individuals to take insulin on a medium to long term could be potentially quite challenging . My opinion is that the evidence may not support the recommendation around 'irreversible damage' specifically, in what is on the whole a comprehensive and well balanced section of the SIGN guidance document.	
	DC	Good	No action required.
	PC	Would think this is an area where a recommendation could be made re prioritising research. mentions here the MHA been involved, not sure how well sits in this part of the section and also needs set in context a little more. Not everyone with Type 1 diabetes and an ED who does not respond to treatment will be suitable for use of the MHA.	Patients with diabetes has been included in the recommendations for research. This has been moved to section 3.4.
	WW	I would like to make a clinical comment. In our health board we have been treating patients with anorexia and insulin dependent diabetes by collaborating closely with diabetic colleagues - e.g. close communication and some joint reviews with a diabetes specialist nurse. We have seldom admitted a patient to an eating disorders unit and I wondered if the study of an outpatient model featured the same close collaboration (i.e. whether that was a confounder for the two studies mentioned of outpatient and inpatient care). It is difficult to reconcile our clinic experience of positive patient journeys with the evidence stated (recognising this does of course happen not infrequently in medicine and I may be simply wrong)	The studies only state that the outpatient progammes included a psychological therapy. The recommendation is for integrated care, with the involvement of diabetes specialists, and it is noted that there is limited evidence that this has to be inpatient care.
8.2	AR	Helpful to include the knowledge base	No action required.
	AGe	Recommendation are clear	Thank you.
	PC	Likewise though less relevant than in above area.	No action required.
Intro	AR	Helpful	Thank you.
	AGe	Explained well	Thank you.

	FB	As the parent (although no longer the direct carer) of someone with AN this is pretty depressing. It also only considers currently available outpatient talking therapies and does not consider inpatient, social support etc. I realise that this is the remit for the guidelines, but think that for all patients a more holistic approach where the talking therapy is PART of the support and treatment available to the patient not the only option would be more appropriate	We agree with an MDT approach. However the question related to this section was specifically focused on the effectiveness of psychological therapies for AN, and it should be viewed within the context of the full guideline. A sentence has been added to section 1.2.1, overall objectives: A holistic and individualised approach to care is required.
	HB	Explain 'BMI [as] attractive measure'. Consider rephrasing 'loved ones' finding a less emotive yet inclusive term?	Changed to 'convenient, objective' measure. Changed to 'family and carers'.
	SG	The use of BMI as a measure for treatment for illness, progress and recovery are extremely divisive and can lead to huge issues at an individual level as they can drive negative behaviour and views. Recovery discussions should be holistic in approach to include attitudes to nutrition and exercise and future focused about life without AN rather than about weight gain and BMI number. Triggers for treatment should also not be exclusively BMI led as this can drive people to restrict eating or disengage with services as they perceive they are 'not ill enough'. Similarly recovery journeys differ by individual and are less about BMI and weight gain and more about individual thought processes on managing life stresses, nutrition and/or exercise.	We agree with this, however in the literature reviewed, BMI was the most common outcome measure. In Section 18.2, one of the research recommendations listed is: The incorporation of a holistic definition of recovery, rather than one focused on weight in isolation, and associated biological and psychological interventions that promote maintenance of recovery following active treatment.
	DC	Well written but not my area of expertise	Thank you.
	RT	I wanted to bring to the panel, the occlusions of a very powerful meta-analysis conducted in 2012 published in the Lancet. Lancet Psychiatry. 2021 Mar;8(3):215-224. doi: 10.1016/S2215-0366(20)30566-6. Epub 2021 Feb 15. Comparative efficacy and acceptability of psychological interventions for the treatment of adult outpatients with anorexia nervosa: a systematic review and network meta-analysis Compared with treatment as usual, specific psychological	This was out with the time limit for the SIGN literature review. The 13 RCTs included in the review are included in the guideline. We have stated "CBT did not demonstrate superiority over other therapies for patients with AN". Which is the same conclusion as this paper.

		treatments for adult outpatients with anorexia nervosa can be associated with modest improvements in terms of clinical course and quality of life, but no reliable evidence supports clear superiority or inferiority of the specific treatments that are recommended by clinical guidelines internationally. Our analysis is based on the best data from existing clinical studies, but these findings should not be seen as definitive or universally applicable. There is an urgent need to fund new research to develop and improve therapies for adults with anorexia nervosa. Meanwhile, to better understand the effects of available treatments, participant-level data should be made freely accessible to researchers to eventually identify whether specific subgroups of patients are more likely to respond to specific treatments.' I would like this to be considered by the panel - it may be that qualifying statements regarding superiority of one treatment over another is still very shaky and is still disputed by the most reputable journals . Secondly, that treatment outcomes are heavily skewed to adolescents and that treatment effects in the adult population are still very modest. When recommendations are made regarding a particular modality, there is no statement given to absolute improvement. In reality, the interventions are graded and that are then presented are on the basis of relative v absolute effects compared to the other interventions, which can be misleading and give the impression of a greater efficacy than actually exists. One way to mitigate against this it to publish NNT data beside each intervention.	At the point of considered judgement, studies were only included if there was a sufficient adult sample. The evidence statements provide the data presented in the studies. Where possible we have included data on mid-points and end of treatment as sometimes the effect wanes over time. If citing NNTs, the context of the study is also needed to ensure comparison in like for like. Better studies are needed, and there is a call for further research in section 18.2.
9.1	AG	No issues. Good use of evidence to hand. Thoroughly researched	Thank you.
	AR	Seems to fit with the literature	Thank you.
	AGe	Adequate information	Thank you.
	AH	Many autistic adults report CBT as unsuccessful due to the	This is covered in section 3.3.3. We would prefer to retain

		focus on emotions and reflection on feelings. Other therapy may be better first line option for those Autistic adults. eg DBT add this into this paragraph	there as it covers sections 5 and 9. Reference to section 3.3.3 has been added to the intro to section 9.
	HC	Good therapeutic relationships are of utmost importance, but can be disrupted unintentionally, when therapists take leave/are sick. Care should be taken to avoid multiple changes if possible.	Agree, but this is standard for any care and not something that needs to be recommended in a guideline.
	SY	No mention of the Arts Therapies. I work on a specialist eating disorder unit and work with patients as soon as their cognitive functioning is restored. I often work with them before the other therapies available because imagery and creativity is often utilised by the patient as a bridge to verbal communication and is seen as less threatening. I combine art psychotherapy with mentalisation and also sensory art and this has been particularly helpful to eating disorder patients who also present with personality disorders. I am also gathering outcome measures for the work that I do	Please see response to FH comments on p10.
	PC	Looks a thorough review with useful conclusions for each section below.	Thank you.
9.2	AG	No issues. Good use of evidence to hand. Thoroughly researched	Thank you.
	AR	Seems to fit with the literature	Thank you.
	AGe	Adequate information	Thank you.
	FH	As previously pointed out, art Therapy can be a first line and second line treatment.	See response to FH comment on p10.
	AH	DBT is reported by many autistic adults as preferable to CBT. First best practice statement doesn't mention ASD as an option. Consider adding this there.	We did not find any high-quality studies in DBT for people with AN and ASD. The examples given in the good practice point are those where evidence was found in one small study and a pilot study.
	PC	Likewise above, found this all the be very informative in thinking about direction of travel for services and needs for future research.	Thank you.
9.3	AG	No issues. Good use of evidence to hand. Thoroughly	Thank you.

		researched	
	AR	Seems to fit with the literature	Thank you.
	AGe	Adequate information	Thank you.
	AL	It is vital if this guidance is to lead to improved care and support that there is explicit inclusion of input into services from Music, Art and Drama therapists	See response to FH comment on p10.
	SY	The Arts Therapies have not been mentioned and I think this is an oversight of its valuable contribution in the treatment of people living with an eating disorder.	See response to FH comment on p10.
	PC	Again informative. I could not see one review referenced that might be of use here-I may have just missed it.Clin Psychol Rev, 2017 vol. 58 pp. 125-140 The empirical status of the third-wave behaviour therapies for the treatment of eating disorders: A systematic review. Linardon, J; Fairburn, CG; Fitzsimmons-Craft, EE; Wilfley, DE; Brennan, L	Thank you. This systematic review is cited in section 9.1, compared to CBT. A reference to it has been added to the introduction of section 9.3.
	RS	We are again pleased to see that a range of other therapies are being suggested as adjunctive therapies where indicated. On page 22, section 9.3.1, a CFT article is outlined with n= 19. The article has been allocated a 1+ rating. We wonder if that rating might be a bit high, given the likely lack of power that n=19 affords to a study.	Thank you for highlighting this mistake. It has been changed to a 3.
9.4	AG	No issues. Good use of evidence to hand. Thoroughly researched	Thank you.
	AR	In line with the evidence presented	Thank you.
	AGe	Recommendations are clear	Thank you.
	AL	It is vital if this guidance is to lead to improved care and support that there is explicit inclusion of input into services from Music, Art and Drama therapists	Please see response to FH comment on p10.
	HB	Recommendations are clear and lead clearly on from previous sections.	Thank you.

	EB	"Or other forms of CBT" – Is too vague and leaves room for clinicians to continue to do whatever they want and call it CBT and say I'm following the SIGN guideline – they should be recommending specific formats for example CBT-E.	This was considered but the form of words was chosen due to the evidence available. Specifically there was not enough to distinguish between formats.
	AT	There could be something about review timescales when a psychological therapy is ineffective, unsuitable or unacceptable as in 9.4, 10.3 and 11.3; e.g. when a therapy is found to be ineffective, could say "other therapeutic approaches should be considered within a six month timescale".	There was no evidence to support a statement on a specific timescale.
	SG	I would like to see some kind of coaching intervention whether in groups or individually to help individuals to manage at restaurants, in supermarkets and cooking etc, too. Often people are discharged from services with just CBT and no assistance to adapt to or handle these types of what are seen to be very stressful activities. This is particularly relevant for recently transitioned people from CAMHS or those leaving residential treatment centres.	This should be included as part of CBT to some degree as the behavioural experiment component. I could be part of occupational therapy. A call for research into occupational therapy in eating disorders has been included in section 18.2.
	PC	Personally, and based on long experience of when things don't go as well as hoped, how it can sometimes leave a residue of distress that can cause therapeutic failure later, I think a target should be research to better define what sort of therapies work better for whom, and in what modality of delivery e.g. individual, group, online. I do wonder if the starting place of CBT-e for all, which I understand the rationale for, maybe hides importance differences and indeed personal preferences.	Thank you. A call for further research, including different modalities is included in section 18.2.
9.5	AG	No issues. Good use of evidence to hand. Thoroughly researched	Thank you.
	AR	In line with the evidence presented	Thank you.
	AGe	Adequate information	Thank you.
	GA	Olanzapine from a primary care perspective would be better considered after specialist initiation in this group of patients. Could this be made clearer in the	Olanzapine doesn't necessarily need specialist input. This would be for agreement between secondary care and the GP for individual patients or location. It is a service provision point,

		recommendations?	therefore out of the scope of the guideline.
	FB	Given the short term nature of most treatment offered it can become problematic if a patient is discharged from ED services but is still on medication. Who monitors the long term follow up. Usually the poor GP as there's no one else to do it.	This is an implementation issue, for local agreement.
	HB	Very real risks are outlined clearly.	Thank you.
	AMc	Oxytocin Is there a better word than refeeding? At time of “eating? Meals? Improving nourishment? Nutritional rehabilitation? Depends on context. Using refeeding can confuse with the refeeding syndrome and perhaps the other terms sound a bit more compassionate to those frightened of eating and weight restoration.	This was based on the title of the paper, however, for clarity, it has been changed to ‘inpatients undergoing nutritional rehabilitation’.
	PC	Summarises the current position well I think, I wonder if a mention here also to the importance sometimes in medication to address comorbidities.	Impact of therapies for comorbidities is discussed but it is outwith the remit to discuss treatment of comorbidities.
10.1	AG	No issues. Good use of evidence to hand. Thoroughly researched	Thank you.
	AR	In line with the evidence presented	No action required.
	AGe	No issues	No action required.
	GA	Please review the spelling of binging. It is not consistent in the recommendation.	Amended to bingeing.
	AH	Many autistic adults report CBT as unsuccessful due to the focus on emotions and reflection on feelings. Other therapy may be better first line option for those Autistic adults. eg DBT add this into this paragraph	This is covered in section 3.3.3. We would prefer to keep it there because it is pertinent to more than just section 10.1.
	SY	No mention of the Arts Therapies. I work on a specialist eating disorder unit and work with patients as soon as their cognitive functioning is restored. I often work with them before the other therapies available because imagery and creativity is often utilised by the patient as a bridge to verbal communication and is seen as less threatening. I	Please see response to FH comments on p10.

		combine art psychotherapy with mentalisation and also sensory art and this has been particularly helpful to eating disorder patients who also present with personality disorders. I am also gathering outcome measures for the work that I do.	
	HB	Useful to see emphasis on need for further research at the start. Useful to see emphasis on face-to-face rather AND remote therapies given the recent pandemic.	Thank you.
	PC	Again looks to be a good summary, and certainly informative. have no doubt I will be referring to sections from this in the future to help guide my work.	Thank you.
10.2	AG	No issues. Good use of evidence to hand. Thoroughly researched	Thank you.
	AR	In line with the evidence presented	No action required.
	AGe	No issues	No action required.
	FH	Art Therapy can be a first and second line treatment used for all eating disorders.	See response to FH comment on p10.
	AH	These may be better options for Autistic adults as above	No evidence specifically relating to better options for autistic adults was identified. Section 3.3.3 discusses the need to consider alternatives for autistic people.
	AMc	"Interpersonal psychotherapy may be as efficacious as CBT, but is associated" For clarity should but CBT is …..	CBT added.
	PC	As previous. Found first line did not make sense though.	'CBT' has been added for clarity.
10.2.2	HB	Is this the first instance EDNOS is mentioned? Should it be introduced earlier? What about the initial focus on AN. BN and BED?	It is already mentioned in section 9.2.3. The studies have been included as they have a mixed population, but the focus is on the participants who had AN and BN.
10.3	AG	No issues. Good use of evidence to hand. Thoroughly researched	Thank you.
	AR	In keeping with the literature	Thank you.
	AGe	No issues	Thank you.
	AL	It is vital if this guidance is to lead to improved care and	See response to FH comment on p10.

		support that there is explicit inclusion of input into services from Music, Art and Drama therapists	
	SY	The Arts Therapies have not been mentioned and I think this is an oversight of its valuable contribution in the treatment of people living with an eating disorder.	See response to FH comment on p10.
	PC	Comments as for Anorexia nervosa.	Thank you.
10.4	AG	No issues. Good use of evidence to hand. Thoroughly researched	Thank you.
	AR	In keeping with the literature	No action required.
	AGe	No issues	No action required.
11.1	AG	No issues. Good use of evidence to hand. Thoroughly researched	Thank you.
	AR	In line with the evidence presented	No action required.
	AGe	No issues	No action required.
	AH	Many autistic adults report CBT as unsuccessful due to the focus on emotions and reflection on feelings. Other therapy may be better first line option for those Autistic adults. eg DBT add this into this paragraph	This is covered in section 3.3.3. We would prefer to keep it there because it is pertinent to more than just section 10.1.
	HC	See section 9.1 comment	Response given in sect 9.1.
	RS	The psychologists within the NHSGGC specialist weight management service are pleased to see that both CBT or IPT are being highlighted as the first line choice for adults with BED.	Thank you. No change to draft required.
	SY	No mention of the Arts Therapies. I work on a specialist eating disorder unit and work with patients as soon as their cognitive functioning is restored. I often work with them before the other therapies available because imagery and creativity is often utilised by the patient as a bridge to verbal communication and is seen as less threatening. I combine art psychotherapy with mentalisation and also sensory art and this has been particularly helpful to eating disorder patients who also present with personality disorders. I am also gathering outcome measures for the	Please see response to FH comments on p10.

		work that I do.	
	HB	Useful, yet somewhat disheartening, to start outlining limits of treatment	We felt it was important to highlight that various options may need to be used.
	DC	Well written but not my area of expertise	Thank you.
11.1.1	HB	Use of terms 'binge eating', BED, binge-eating episodes could be clearer	We have revisited papers. All papers in the CBT section met criteria for either DSMIV or DSM5 BED (and one also included binge eating – which is stated). Binge eating outcome terminology varies slightly across studies and for consistency, we used the terms reflected in the papers referenced.
11.2	AG	No issues. Good use of evidence to hand. Thoroughly researched	Thank you.
	AR	In line with the evidence presented	No action required.
	AGe	No issues	No action required.
	AH	See 11.1	This is covered in section 3.3.3. We would prefer to keep it there because it is pertinent to more than just section 10.1.
11.3	AG	No issues. Good use of evidence to hand. Thoroughly researched	Thank you.
	AR	In line with the evidence presented	No action required.
	AGe	No issues	No action required.
	EM	The way this is worded, there seems to be some regret that binge-eating disorder people cannot result in reductions of BMI. That focusing on BMI reduction may not achieve this aim. Given that many clinicians will not have the awareness you do, and will have a bias against higher weight and an urge to see people achieve lower weights, and that this is part of the culture patients are in too, could you reword to show a strong Health At Every Size - type of message? Can you remove in 11.3 "People who are overweight or obese"? The message should be the same whatever the size: that treatment is not about losing weight. How do you feel about using terminology such as "larger body" instead of "overweight or obese", given that some people categorised as 'overweight' on a BMI chart will be	'overweight or obese' has been removed and the sentence changed to: Psychological therapies do not directly focus on weight loss in those with BED but on improving a person's relationship with food regardless of their size, and may not result in reduction of BMI. We agree about a consistent message, however in our experience many people approach services with a goal of weight loss and it seems important to be open and upfront with people from the outset that this is not a focus of treatment.

		at a weight that is healthy for them.	
	AL	It is vital if this guidance is to lead to improved care and support that there is explicit inclusion of input into services from Music, Art and Drama therapists	Please see response to FH comment on p10.
	RS	We understand the recommendation against dieting during psychological treatment for BED, whilst a client is experiencing an active eating disorder; however from a practical perspective, we wonder whether something could be said about dieting/weight loss being safe once bingeing is under control/markedly improved. For many clients who are living with BED and comorbid obesity they will wish to also lose weight in the longer term, as BED often causes weight gain and BED treatments generally do not encourage loss. It may be that something could be said about clients with a history of eating disorder being considered for weight loss approaches but supported by a suitable specialist weight management MDT with access to psychological support, as best practice. In line with the NHS Scotland minimum standards document for delivery of tier 2 and 3 weight management services for adults. As I asked about at the consultation webinar event, it would be helpful for some recommendations to be made about what services may provide such therapeutic approaches, however I understand that this may not be the remit of this particular guidance document and further guidance will hopefully be provided by the review of eating disorders services via Scottish Government.	The question relates to – psychological treatments for BED. We do agree that clinically people with BED often wish to seek weight loss treatment following psychological intervention. We are not aware of any literature to support this suggestion. Dieting would remain a risk for weight loss. The only treatment which has safely led to improvement both in eating disorder and led to simultaneous weight loss is the Brief Strategic Therapy. A second RCT is underway, and if these findings are replicated, this may provide an option in future for those who wish to address both eating disordered behaviours and weight. Yes, this was not part of the remit of this question and we came across no evidence to support this point, although we did not specifically look at this. It would be helpful for ED, weight management, MH and probably others to link up and consider this.
	SY	The Arts Therapies have not been mentioned and I think this is an oversight of its valuable contribution in the treatment of people living with an eating disorder.	Please see response to FH comments on p10.
	HB	Phrasing 'CBT [...] should be used' is used in the R for AN, BN and here for BED in an identical way regardless of what the introductions say about the general limits of such therapy respectively. Could R reflect limits, especially given the fact that they might be read in isolation?	This has been changed to 'should be considered'. 'overweight and obese has been changed to: Psychological therapies do not directly focus on weight loss in those with BED but on improving a person's relationship with

		R for 'People with BED who are overweight or obese' could be clearer regarding the relationship between reduction of BMI and addressing the ED.	food regardless of their size, and may not result in reduction of BMI.
	EB	What about Guided self help for Adults with BED – at least as an option. There's no mention of group-based CBT.	We are aware in the NICE guidelines that guided self-help CBT is recommended as a first step. We avoided separating forms of CBT as we had stated that more robust evidence is required to determine which mode of delivery is most effective. It is stated that most 'therapist lead' studies were group based. There were no meta analyses that directly compared group interventions to other types at more than an individual therapy/study level.
11.4	AG	No issues. Good use of evidence to hand. Thoroughly researched	Thank you.
	AR	In line with the evidence presented	No action required.
	AGe	No issues	No action required.
	HB	Second paragraph, 'Although sustained weight reduction ...' is very clear in outlining the link between 'pursuit of weight loss' as a 'maintaining factor for ED thinking', and it is useful to have gaps in research highlighted.	Thank you.
	PC	I do wonder if a bit more needs to be written around the evidence base or otherwise for Topiramate and why maybe not discussed more in this document. Typo in this section.	Information in the identified papers regarding topirimate is only a brief statement in the systematic review (Reas 2020) – further review of original articles, shows that both targeted weight loss, and medications were only effective in combination with CBT. There was drop out due to side effects, particularly in the zonisamide study. This has been added to the paragraph starting 'Ten out of 12 studies…'
	AG	Reasonable summary however the only efficacious treatment is weight gain. One would very rarely, if ever resort to anti-resorptive or anabolic therapies in this patient group. Bone density gain from therapeutic intervention can be quickly lost on cessation of said therapies. Additionally bone density gain, albeit potentially temporary, may be deemed a surrogate marker for 'well-being or at least	Agreed, and this is what the guideline states. BMD is a surrogate marker, but there is no evidence to link with "wellbeing", however that is defined. Weight gain or return of menstruation may be equally good markers but there was no evidence on which to make a

		improvement' without this being the case.	statement.
	AR	Very helpful to include this	Thank you.
	AGe	Explained well and is worth including	Thank you.
	GA	Has this section had rheumatological input? There is often controversy in this area and we note the absence of DEXA scanning in this recommendation. Can the reason for this be clarified?	There was no formal rheumatology input, however, the section reflects the available evidence. No evidence was found regarding the value or frequency of DEXA scanning in patients with AN. A sentence has been added to the guideline to say this.
	HD	Would be useful to have recommendations for when BMD scans should take place and frequency of scans of low BMD identified	No evidence was found regarding the value or frequency of DEXA scanning in patients with AN. A sentence has been added to the guideline to say this.
	KB	Could be more clarity on different recommendations for YPs? Bisphosphonates not recommended for younger patients is stated, but what about hormonal treatments? No mention of risk of premature epiphyseal fusion - I am aware this is not an issue with transdermal oestrogen and physiologically pulsatile progesterone, but there should be some discussion (positive or negative). No mention of factors potentially explaining why association of higher BMD with reduced fractures may not hold in those with EDs (i.e. microarchitecture abnormalities)	The only proven therapy in younger people is weight gain and refeeding to a “normal” weight as we state. Evidence on hormonal therapy is summarised in the guideline. “No significant increase in BMD was observed following administration of oral contraceptives, transdermal testosterone or oral dehydroepiandrosterone (DHEA) alone. Conversely, 100 μg of 17-β estradiol (with cyclic progesterone) administered transdermally did increase spinal and hip BMD in mature adolescents with AN.” No evidence on epiphyseal fusion was noted. We recommended discussion of individual cases with a bone metabolism service.
	CV	Within the literature would it indicate under what circumstances and when Dexa scans would be recommended?	No evidence was found regarding the value or frequency of DEXA scanning in patients with AN. A sentence has been added to the guideline to say this.
	HB	Good to see an attempt at balancing info on women and men (here re BMD).	Agreed but markers of recovery are more difficult in men and probably BMD is the only objective measure as no resumption in menstrual cycle is available to act as a surrogate marker of a return to physiological function of the hypothalamic pituitary axis.
	KBr	Bone Health. I would like to change the link for the document ‘exercise activity osteoporosis with an eating	Thank you. The revised link has been added.

		disorder absolutely final for pdf finally 7' on our Physiotherapy Eating Disorder Network group so that it has a different title. I will be able to edit this link for you. I see that this has been translated into the guidance document from the wording on the website and has resulted in the authors informal title being used. I will make changes to the title on the website but please let me know the best way to resend the link to the edited in the guidance.	
	LS	I was uncertain as to what is the current prescribing guidelines around this? Clarification around contraceptive pill use in adolecents and if this is advised to support bone mineral density.	Contraceptive pill might be option as adjunctive therapy in some cases, but the only clearcut evidence is around weight gain to a "normal weight" which in women probably includes a resumption of the menstrual cycle.
	SG	Recommend - Follow up bone density scan 5 yrs post discharge as standard to check impact of illness longer term and to build into subsequent treatment plan if needed.	This is for individual services to decide but no definitive evidence around whether it alters management of outcomes. A sentence has been added to say there is a lack of evidence.
	DC	Interesting and important to highlight Paediatricians and primary care need to be aware of this	Agreed.
	AMc	"Refeeding to a normal weight" what about recovery to a healthy BMI and resumption of menses / menstrual cycle. (Both are required for bone density) Progress can be slow- is this because bone turnover is slow. There is no mention of DXA scans in this section. It could be helpful for clinicians and patients to know if this diagnostic test is worth carrying out and given slow change frequency of repeat if it should be repeated at all. The first recommendation, weight restoration should be offered to all patients of all genders and ages with low weight anorexia (should nervosa be added). Is the word low necessary? By definition people with AN have low weight. It is my understanding that individuals need to be a BMI of 19 to benefit from any weight bearing activity.	These are covered in the draft, and also in refeeding section. A sentence has been added to say no evidence found on value of DXA. Low weight is associated with loss of menstruation and poor bone health. Weight restoration by definition is not required in fully recovered AN patients of normal weight, but they may still have osteoporosis. Most studies did use a BMI of around 19 to define weight restoration but no evidence that 19 is a cut off for bone health. Indeed, menstruation, which is probably a useful marker of hypothalamic function, can occur at lower BMIs, so a definitive statement not possible.
	PC	Worth highlighting evidence on use of DEXA scans	No evidence was found on DEXA scans. A sentence to say

		including frequency and of course in younger people?	this has been added.
	WW	Good summary highlighting the challenge of keeping weight restitution as a central message supported by evidence.	Thank you.
	SGF	-Vitamin D is generally lower in non-white minorities in the UK population so supplementation may still be recommended, to also improve absorption of dietary calcium and phosphorus -Low adipose tissue in all anorexics leads to lesser storage of excess vitamin D -?DEXA scan to be used as a motivational tool in therapy to monitor progress	Agree that vitamin D has a role. Appropriate vitamin D is mentioned, but it is also noted that it does not have any direct effect on osteoporosis. No evidence was found on DEXA scans. A sentence has been added to state that.
	AG	No issues. Good use of evidence to hand. Thoroughly researched	Thank you.
	AR	Helpful to make us aware of the nature of the illness	Thank you.
	AGe	No issues	Thank you.
	GA	Pg 36, Line 13 Can you consider adding the option of booking to be seen by the primary care team/ review by general practice team as an opportunity to reengage with care and therapy? line 23. Disorder- typo. The "I" is missing from the word	We were unclear where you mean on p36 – however we have added a statement (which may start with primary care) at the end of the paragraph starting ‘a fluid approach’. Thank you, typo has been amended.
	HD	I would argue that an individual with ED can never have capacity to choose end of life care as their decision will be influenced by the nature of their ED and likely cognitions associated with low weight. It is disappointing to see end of life care advocated as an approach	We feel this would be exceptionally rare and it is imperative that it is considered with the upmost care, alongside all stakeholders. We do however feel it is important to suggest ways on how to approach this as there are rare cases where this is considered.
	AL	It is vital if this guidance is to lead to improved care and support that there is explicit inclusion of input into services from Music, Art and Drama therapists	Please see response to FH comments on p10.
	KB	This section is thoughtful and balanced and I certainly welcome the discussion of flexibility around the "relentless imposition of therapeutic tasks"! We in CAMHS struggle most with this. While I certainly understand the need to	Thank you.

		avoid unjustified therapeutic pessimism, I think there is also a need to practice "realistic medicine". A patient once told me that "the only thing worse than no hope is false hope". Perhaps the most hard-learned lesson of my career and worth bearing in mind in this context...	
	HC	Totally agree that weight restoration is so difficult for these patients and should be sensitively managed, taking into account the patient's holistic needs. They also need to know that little steps are ok. We find that some of our group members find the prospect of fully maintained recovery just too daunting. This is where support from others who have been there and consequently succeeded, can bolster their confidence in what they can achieve. There also needs to be some flexibility for these patients to be able to return to treatment if need be to prevent downward spirals. Services would need more suitably qualified staff and resources to be able to achieve this. There also needs to be appropriate support for families and carers of those with SEEDS patients.	Thank you. We have added a sentence, 'It may be that part of this involves the modification of goals which focus on smaller steps that aim to maximize safety in the context of what feels achievable to the individual.' Support: we added an information point signposting to peer support and support for family and carers. We agree with the flexibility to return to treatment and likewise with families and carers.
	HB	Useful to read emphasis on 'the course of an ED is always individual' in the starting sentence. Would it be useful to bring in here the emphasis on qualitative research and patient-centred research into lived experience? There is scope to define/explain '[poorer] ED quality of life' Could the last paragraph before R (inc. 'medico-legal involvement') be linked back to 3.4. 'Using the Mental Health Act' (and vice versa)?	The focus of this section is to report on published results rather than discussing research methods. The study used ED QOL scores. The wording has been changed to 'those with AN purging subtype and the worst scores for ED quality of life were less likely to complete treatment'. A link has been added to section 3.4.
	DW	We welcome the recommendations that acknowledge the need to continue to support those people with severe and enduring eating disorders and provide services that can improve quality of life to some degree.	Thank you.
	AT	Severe and Enduring Eating Disorders – "Continuing to offer intervention for those with a long course of ED in the context of ongoing research. This	

		seems particularly important as there is the potential for the terms used to define longstanding EDs (e.g. chronic or treatment resistant) to inappropriately result in loss of hope and unsuitable discharge from all treatment, as well as increasing stigma" (2nd paragraph, p36). We know what a complex area this is, and there should be mention that MWC and CLO are contacted. There should be a recommendation about more robust clinical reviews, at least annually which include re-assessment, with a "could" in relation to having a 2nd or independent review.	The following sentence has been added to the penultimate paragraph: The Mental Welfare Commission for Scotland and Central Legal Office involvement can be considered to support treatment decisions at any stage of their care and second opinions can be sought. 'This should be supported by robust ongoing clinical reviews'. Has been added to the good practice point.
	DS	"It may be helpful to move from active targeting of ED symptoms to a more holistic approach, concentrated on optimising and maintaining a better quality of life and wellbeing, whilst minimising the negative impact of the ED as far as possible." I particularly liked this statement in the SEED section, however felt it was applicable throughout the guidelines for all eating disorders and ages and genders. I thought it was a good way of introducing the option of Occupational Therapy - and other treatment options; there is only a short paragraph on physiotherapy intervention. The guidelines do feel rather 'psychology heavy' and sometimes our patients are not up to working within that approach either cognitively or physically, but can work with a more practical,pragmatic approach.	Thank-you for this and we really value the importance of Occupational Therapy (and other allied professions) across the treatment of people with eating disorders. However, we came across little high-quality evidence to support this approach in people with SE-ED. A sentence has been added to section 1.2.1 to explain this: A holistic and individualised approach to care is required. The guideline focuses on therapies with an evidence base. Other therapies, such as arts therapies, occupational therapy, physiotherapy, and speech and language therapies, play an integral part in the management of patients with eating disorders, but a lack of robust research did not allow for their scrutiny in an evidence-based guideline.
	SG	The focus should be on life without the eating disorder as mentioned and the positive influences of this. Support with managing the disorder should continue for as long as the patient feels it is valuable and multiple options should be considered through discussion with the individual. Often the individual doesn't know what support or intervention they might need and closes the discussion down as the topic is overwhelming and stressful, the skill of the professional is in coaxing and encouraging this from the individual through discussion to enable a treatment	We do agree with this to an extent and to promote wherever clinically indicated. However, we know that often people live with eating disorders for many decades and not meeting them at a place where they feel they are at can increase ambivalence and disengagement from services. We agree with your second point and feel that this has been conveyed.

		plan to be determined.	
	DC	Well written and informative	Thank you.
	AMc	Poorer ED symptoms, for clarity what are poorer ED symptoms. This section mentions a recent meta analysis that found no relationship between duration of ED and treatment outcome yet earlier in the document it talks about FREED and early intervention. Is this slightly contradictory? I have asked in the early intervention section Is FREED's age criteria/ duration criteria come from research / evidence.	This relates to a range of ED symptoms as assessed by the EDEQ. Changed to 'worse'. The meta-analysis in this section did not set limits on age range and thus included studies of children, adolescents and adults. FREED is for people considered to be in early adulthood (18-25) and there are a number of papers that outline the rationale for the focus on this group of people for rapid intervention. We could not compare results for EA to the wider ED population. Radunz and colleagues also highlighted heterogeneity across studies and limitations within the research which make conclusions difficult. They also discuss the possibility that ED duration may predict outcome in certain but further research is required to establish such links.
	PC	Worth mentioning the term or how it is labelled itself is being challenged heavily now? Helpful summary of the evidence.	We have stated that there is no consensus on how it is defined, so think this is covered.
	WW	I would like to make one observation, stating first that I found this section to be sensitively and imaginatively written - in an area where evidence is lacking. As with the revised MATRIX of psychological therapies, is it worth making mention that whilst the evidence exists for only a few treatment modalities, where a coherent expertise and culture of practice exists locally this in itself may be of value for clinicians and patients needing to try and different approach or to get past therapeutic nihilism. e.g. in our service , I found that CAT , or even art therapy would sometimes give benefit more by dint of being different and a fresh start.	Thank you. After consideration of alternatives we have added: which may include innovative interventions if coherent expertise is available.
14.1	AG	No issues. Good use of evidence to hand. Thoroughly researched	Thank you.
	AR	Very helpful to include this	Thank you.

	AGe	No issues	No action required.
	AL	It is vital if this guidance is to lead to improved care and support that there is explicit inclusion of input into services from Music, Art and Drama therapists	Please see response to FH comment on p10.
	HC	Attitude of midwifery and obstetric staff is very important. Education is key here once again, so that all staff have a working knowledge of eating disorders, how to react to patients with eds sensitively, and how to access expert advice if necessary. The patient must feel comfortable enough to be able to share any concerns with her midwife/consultant.	Comment noted. Section 14.7 covers training for health professionals working with this group and Section 14.1 makes a recommendation for healthcare professionals to routinely sensitively enquire about eating disorders.
	HB	The sections on 'barriers to disclosure' were very informative. Is there scope to bring in similar points regarding other EDs (outside pregnancy and postnatal period)? This section with its integration of quotations from women with lived experience reads differently from other sections. Is there scope to include similar approaches (e.g., quotations from interviews) in other sections?	This guideline is piloting the incorporation of qualitative research into the SIGN methodology so was used in a few sections only. These comments will be added to the feedback on the pilot.
	DC	Interesting and important to highlight	Thank you.
	AMc	2nd paragraph Does the word dysfunctional need to be there? What about improvements in eating behaviours. 5th paragraph last sentence “level of knowledge about ED and acknowledgement of their symptoms” for clarity is this a lack of knowledge in maternity services? Last paragraph Specialist ED dietetic assessment and intervention or treatment. I think it is unnecessary to put and weight monitoring. This would be part of any intervention if highlighted as necessary as part of a dietetic assessment. Unless what this is trying to convey is weight monitoring is important by other health professionals if not been seen by	‘Dysfunctional’ has been removed. This has been clarified as ‘their level of knowledge about their ED’. Different areas have access to different services and weight monitoring may be considered by other health professionals in the absence of dietetic input, so it is felt that this should be retained.

		a dietitian.	
	PC	Again -more priority for research, given long term effects on children possible?	This has been included in the recommendations for research.
	WW	Very good overall. In recommendations, is it worth clarifying if clinicians should 'routinely' ask sensitively about a history of eating disorders and in which setting (general maternity pre/postnatal or mental health)	The wording has been revised to: During pregnancy and postnatally healthcare professionals should routinely sensitively enquire if the woman has a current or past history of eating disorder and be aware of potential barriers for disclosure.
	KJ	for Obstetric management 1) serial growth scans at 28,32,36 weeks because of the risk of growth restriction 2) Add in Vitamin D deficiency as they are at risk of all nutritional deficiencies, and this is recommended to be taken in pregnancy 3) Early treatment of GORD should be considered to avoid nausea and vomiting which may trigger a recurrence of ED	These are areas that would benefit from further research and possibly consensus best practice guidance in the future. It would not be the scope of this guidance to make a recommendation given the limited evidence base in this area.
	SMcC	Is there anymore data on symptoms during the third trimester? Generally appetite can decrease due to reduced stomach capacity also the third trimester can impact hugely on poor body image symptoms. There can also be more gastric symptoms such as indigestion that can impact on dietary intake on women with eating disorders also those without. It would be good to get a comparison of data here rather than first and second trimester and then jump to postnatal period.	Unfortunately it was not within the scope of this guidance (which focussed on evidence for intervention) to make such a detailed and specific recommendation given limited evidence base in this area.
14.2	AG	No issues. Good use of evidence to hand. Thoroughly researched	Thank you.
	AR	Co-morbidity is common	Comment noted. The section reflects the evidence identified in this area.
	AGe	No issues	Thank you.
	AL	It is vital if this guidance is to lead to improved care and support that there is explicit inclusion of input into services from Music, Art and Drama therapists	Please see response to FH comment on p10.

	SMcC	It is important to highlight how prevalent this is. Also women can present with anxiety and depression symptoms initially and not disclose eating disorder symptoms or poor body image till later on , although these can contribute to anxiety and depression developing in the first place. The core of the eating disorder cause can get missed as professionals focus on the anxiety and depression	Comments noted but no change to the draft required.
14.3	AG	No issues. Good use of evidence to hand. Thoroughly researched	Thank you.
	AR	Useful overview	Thank you.
	AGe	No issues	Thank you.
	SMcC	Absolutely important to highlight to women the pros and cons so they can make an informed choice. All staff should ensure that women have access to the correct accredited information on medication use specifically anti depressant use in the perinatal period which would also include impact on breastfeeding and potentially the neonate.	Comment noted but no change to the draft required. This is already included in a good practice point.
14.4	AG	No issues. Good use of evidence to hand. Thoroughly researched	Thank you.
	AR	Valuable	Thank you.
	AGe	No issues	Thank you.
	SGF	Need to be aware of specific cultural practices of 'pregnancy diets' in BAME and minority communities that may inadvertently or intentionally mask eating disorders +/- cause deficiencies	Comment noted. There is no evidence to support making a specific good practice point or recommendation however this is an area that is underserved by research and would benefit from further investigation.
	SMcC	Important to note, also has any research been looked at for women who have had or are experiencing an eating disorder who are breastfeeding ? if so what are the reasons for?- the good of the baby? or do any admit to using breastfeeding as a way of using calorie intake to control their weight? I think it would be prudent to mention this somewhere in the guideline to raise awareness that this may be used	This is an area that would benefit from further research and or consensus best practice guidance in the future.

14.5	AG	No issues. Good use of evidence to hand. Thoroughly researched	Thank you.
	AR	Helpful	Thank you.
	AGe	No issues	Thank you.
14.6	AG	No issues. Good use of evidence to hand. Thoroughly researched	Thank you.
	AR	Very useful	Thank you.
	AGe	No issues	Thank you.
	HB	The term 'children of mothers with EDs' could be more refined indicating age range of these children, e.g. are they infants?	The systematic review included studies looking child development from birth up to age 12y so the term ‘children’ is appropriate. The age range has been added.
	SMcC	Important to note, also has any research been looked at for women who have had or are experiencing an eating disorder who are breastfeeding ? if so what are the reasons for?- the good of the baby? or do any admit to using breastfeeding as a way of using calorie intake to control their weight? I think it would be prudent to mention this somewhere in the guideline to raise awareness that this may be used	This is an area that would benefit from further research and or best practice consensus guidance in the future.
	SMcC	Very important to highlight potential adverse infant outcomes I do not think this is done enough due to lack of awareness of staff who do not feel confident enough to discuss with women and may leave it to eating disorder colleagues which of course can impact on potential early intervention by the time the referral ensues	Comment noted. We hope that we have sensitively highlighted the needs of the infant whilst also acknowledging the limited evidence and research findings in this area.
14.7	AG	No issues. Good use of evidence to hand. Thoroughly researched	Thank you.
	JW	SAS would welcome proportionate educational resources for SAS clinicians who may be required to attend people affected by eating disorders.	Comment noted. No change to the draft required.
	AR	Of importance	Comment noted. No change to the draft required.
	AGe	Could highlight specific training programmes	There is insufficient evidence to suggest specific training programmes as a good practice point or a recommendation.

	HC	See comment for 14.1	Response given in 14.1.
	CV	For pregnant adolescents with ED - awareness, training and education could make note to specifically Family Nurse Partnerships programme staff who are the main or key professionals involved in screening and supporting mental health with pregnant teens.	FNPs are included as part of the extended MDT in section 14.1.
	HB	'Training and education' raises many valid points sensitively, and is different in style and approach to the other sections. Could this approach be taken up in other sections?	This guideline is piloting the incorporation of qualitative research into the SIGN methodology so was used in a few sections only. These comments will be added to the feedback on the pilot.
	SGF	Liaison with other healthcare professionals by setting up specific patient care peri-natal MDT group for joint care Increased carers support for brief duration	Section 14.1 highlights care planning with the extended MDT.
	SMcC	Crucial to have more training and education is it possible to state specifics? are there any national training on eating disorders being implemented at this time so staff can access? is the guideline able to highlight and recommend? Staff can feel uncomfortable asking women for dietary intake and do not know how to deal with the answers if there is a problem, clear pathways needed for care, referral criteria and treatment options	This is an area that may benefit from consensus best practice guidance in the future. The Implementation Group for the National Review will be addressing training needs.
15.1	AG	No issues. Good use of evidence to hand. Thoroughly researched	Thank you. No action required.
	AR	Helpful to include this	No action required.
	AGe	No issues	No action required.
	AL	It is vital if this guidance is to lead to improved care and support that there is explicit inclusion of input into services from Music, Art and Drama therapists	Please see response to FH comment on p10.
	KB	?diverse body image. Does this mean a staff group with a variety of body types or in degree of body image satisfaction or both? Ambiguous, and difficult to implement in any case. I was unaware of higher mortality of male inpatients. There is no discussion of why only inpatients: lack of evidence in	Agree. 'body image' removed from the good practice point. This is only in-patients as this is the population in the study. This was a single study and thus we were unable to make a recommendation based on this. The text has been amended to

		outpatients or evidence of lack of difference? Helpful to clarify - do all ED clinicians need to be extra concerned in male patients or are there male specific hazards in IPUs?	clarify that this was one study in inpatients.
	HC	A working knowledge of eating disorders in men and boys is needed by all medical students, nursing students and those in education, so that they can spot signs as early as possible, and be able to access guidance or refer to the appropriate professional services if required.	One of the recommendations is for further teaching and training. It is hoped that implementation of the guideline will increase awareness and knowledge.
	CV	Helpful list of key themes	Thank you.
	SY	The Arts Therapies have not been mentioned and I think this is an oversight of its valuable contribution in the treatment of people living with an eating disorder. I have found that men living with an eating disorder have been very receptive to the art psychotherapy process. I have found that they engage well with the process and find it a helpful way to communicate and express the challenges and thoughts surrounding their eating disorder.	See response to FH comment on p10.
	HB	'Striving for muscularity to be added to 'lower drive for thinness'? Add separate points on barriers for helpseeking and gender bias in healthcare professionals?	We agree this is likely but it is not what the study reported. There are already points from the studies about barriers to help seeking, and comments about lack of understandings of gender issues, which we think adequately cover these points.
	DC	Good to highlight recognition and different clinical features	Thank you, no action required.
	PC	Feels like there should be more to this section, but I could not identify any gaps re the evidence. Research again?	The section reflects the most recent evidence identified in the literature review. The need for further research is highlighted in section 18.2.
	SMcC	Should we highlight dads and partners of pregnant women? If a pregnant woman has a re-occurrence of eating disorder symptoms can this trigger her partner who may also have one? how rare is it for dads to have eating disorders? Dads can sometimes be forgotten about and as the perinatal period can be a time of immense strain for a dad also and its only recently that we have started to address the mental health needs of dads at a national level.	This wasn't part of the key question, and is unlikely to have an evidence base at the moment. Nothing was found in the key question specifically on the needs of men. It could be considered when the guideline is updated in the future.

15.2	AG	No issues. Good use of evidence to hand. Thoroughly researched	Thank you.
	AR	Gender issues need to be included	Gender issues are included where evidence was identified, particularly in the qualitative studies.
	AGe	No issues	No action required.
	AL	It is vital if this guidance is to lead to improved care and support that there is explicit inclusion of input into services from Music, Art and Drama therapists	Please see response to FH comment on p10.
	KB	Interesting to note benefit of transition on the ED.	No action required.
	AH	A large percentage of this population are also Autistic and therefore consideration must be given to this as another factor in treatment, care and follow up.	This was not identified in any of the studies reviewed in this section. Further advice on autism has been added to the introduction of the guideline.
	HC	See comment for 15.1	Noted, no action required.
	HB	Consider rephrasing 'gender issues' to 'transgender issues'.	The research actually considered gender, including male, female and trans populations so this was not just limited to trans. Gender issues is correct.
	JMc	More education on knowing what might be triggering/difficult for a patient to be asked/to speak about and also on how to respond/handle the situation best. Also, just a thought, but is gender the right word to use when talking about weight restoration and things related? Would be something to discuss with people who have experience in this field, but perhaps using 'sex' to discuss these things would make it less damaging as that is biological and not to do with how they wish to be seen/acknowledged by others? I am not 100% sure on this but was something that came to my attention when I was reading so thought it might be worth mentioning.	Agree more education would be helpful. Ongoing work is being done in this area but was not covered in the studies identified. The recommendation has been amended to ‘sex differences and issues relating to gender’ to encompass both.
	LS	More investment required to provide information, training, resources and support for staff and yps/family	Agree. This is an implementation issue.
	AMc	LGBTQ+ are a diverse group in themselves. This section Only discusses gender it does not discuss sexuality so	Agree this is a diverse group. We have only reported on the evidence available. There are a number of other studies and

		LGB does not get a mention. Is there no research on this worth mentioning? In the 17 years I have worked in the field of ED I have worked with many LGB people and only one trans person. It doesn't seem inclusive to have LGB people in the heading and then not mention them. In Trans individuals it is a complex situation as weight regain can be associated for a trans man as becoming more feminised (increase in breast tissue and curves) and it can be challenging to see what is driving weight loss. It mentions that health professionals address their own unintentional biases and negative assumptions about transgender people. Is this because it has been found that there is more bias toward this group than other minority groups? We should all be reflecting on our unconscious bias about overweight people, BAME people, LGBTQ+ people given the society we have grown up in. I wonder if one of the recommendations could be that people who work with individuals with ED receive specialist training on transgender and how this may affect treatment for an ED and are signed up to equality and diversity and training on same.	ongoing research looking at LGB populations but this work has not been published in a way that can be used according to SIGN methodology. A sentence has been added to the section to make this clearer. We are not saying that there is more bias towards this group than to other minority groups. The qualitative studies highlighted biases and while we should all be reflecting on all of our biases as you say, the section is on LGBT populations so this is what the recommendation is about. The phrase 'negative assumptions' has been removed. An addition has been made to the recommendation on training to make people aware of diverse needs during treatment.
	PC	No additional comments...as above	No action required.
15.3	AG	No issues	No action required.
	AR	Useful	No action required.
	AGe	No issues	No action required.
	BC	There has been very limited research in to how CBT-E can be adapted to support children and young people where the traditional model has been ineffective. In acute medical settings a collaborative holistic approach is used to enhance treatment outcomes for children and young people with ASD or other neurodevelopmental difficulties Quantitative and qualitative research into how adjunctive speech and language therapy approaches can support and improve treatment outcomes would be valuable	Agree, more research needed.

		addition to the evidence base.	
	HD	Would have been good to see a section on EDs and autism as it is such a frequently occurring co morbidity. Also recommendations for when autism assessments should be carried out eg. After weight restoration in order remove confounding of cognition associated with low weight	No evidence was identified on the efficacy of specific therapies for autistic people. References to the expert-opinion based guidance, the PEACE Pathways, and SIGN 145: Autistic Spectrum Disorders have been added to the introduction.
	AL	It is vital if this guidance is to lead to improved care and support that there is explicit inclusion of input into services from Music, Art and Drama therapists	Please see response to FH comment on p10.
	CV	Would it be useful note that in practice often ED/MH services need to link with services prescribing hormone treatment such as endocrine depts or gender identity services that clients may be accessing/being supported by during transition or for pre-post transition support and work together to on formulation, considering impact on puberty and associated body changes, body weight, body image etc	Good practice point added.
	HB	Commend R2 in particular	No action required.
	EB	Recommendation 4 – This is not only relevant to Outpatient care. Last tick on this list – It's important males can access inpatient ED treatment if they need it. All wards in England (accept the few that have dormitory wards) accept males without problems following CQC clarification and publication of this article - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6465224/	'Outpatient services' removed from recommendation.
	AT	There could be quite a significant resource and cost allocation for this, and why would this only be for diverse communities, and not for the other areas where teaching and training would be useful e.g. complex and comorbid conditions, SE-ED etc. consideration should be given to this as an overarching recommendation.	This has been included as a key recommendation, so should be seen as overarching.
	SGF	Liaison with local Gender Clinics to provide integrated care for transgender patients addressing body dysphoria in addition to ED/body dysmorphia	A good practice point has been added suggesting joint working between gender clinics and ED services.

		Effecting organisational change and awareness to ensure appropriate identification of gender on e-Health records of patient to minimise psychological distress	Outside the remit of this guideline.
	SMcC	Highlight these and make them concise and easily accessible for staff to read in the first instance for each subject group.	Unsure what this comment refers to, whoever, all recommendations will be provided in a quick reference guide,
	AG	No issues	Thank you.
	AR	Valuable resource	Thank you.
	AGe	No issues	Thank you.
	EM	Please would you include FEAST? It is a well-respected international source of parental information and support.	FEAST has been added.
	GA	Please note there is an omission for dental advice in this group of patients Would it be worth considering adding a section on assessment, including which blood tests to undertake and whether a DEXA is useful?	Assessment is out of the remit of the guideline. No evidence was found on when or if to use DEXA.
	HC	Totally agree that patients and carers need support to understand the diagnosis, treatment and self care. Patient involvement in decision making is very important to feel a sense of ownership and importance, as the illness makes them feel of little or no worth. Carers need to know how they can help and also what is not helpful. Above all, patients and carers must always be offered hope, and accept that there may be blips along the path to recovery, but that does not mean total failure. Also patients and carers need to know where to access support.	Comment noted. We hope that section 3.2 can help support families and carers, and that the points listed in section 16.3 will encourage shared decision making. We have included a point to emphasize that there is hope.
	HB	Is it worth pointing out 'helpfinder' functions in some of the resources for a more localized approach?	The resources listed may not have helpfinder functions, but we have included Scottish-based organisations that can direct people to local support groups.
	DC	Helpful resources I wasn't previously aware of some of these We found providing a list of reliable sources of info invaluable as parents of a sufferer	Thank you. No action required.

		I think this section is very useful	
	SGF	As previously stated, would be useful to provide translated versions (or arrange on demand)	These are arranged on demand.
	NHS24	Page 44 – this information about NHSinform is correct. Our eating disorder content was updated in 2020.	Thank you. No action required.
16.3	HB	I found it problematic that the checklist is not 'exhaustive or exclusive'. I think you could broaden it to include info on men, transgender and ethnic minorities otherwise the gaps are too obvious.	We have added a point to take into consideration people's individual needs.
	AG	No issues	No action required.
	AR	Will have to see how this goes	No action required.
	AGe	No issues	No action required.
	HC	Desperate need for all NHS authorities to "sing from same hymn sheet". Difficult but very necessary to provide smooth transitions for patients across levels of care and across regions. Resourcing suitably qualified staff is of optimum importance, as is a basic education in eating disorders for all those working in healthcare, education in occupational health.	The recommendations in the guideline will be addressed by the Scottish Eating Disorders Services Review national implementation group, and will hopefully resolve these issues.
	CV	Collect appropriate, nationally-agreed baseline and outcome data (BMI, EDE-Q, DASS and CORE) on all patients - is it worth adding weight for height and possibly EDE-A (?validty / access to norms but suggested on CORC) or RCADS(8+) for younger populations where often dont refer to BMI and EDE and DASS for 14+ only	The names of outcome measures have been removed. These should be agreed by the national Implementation group, recommended in the Scottish Eating Disorders Services Review.
	EB	Chapter 3 also seems to be missing any recommendations on provision of information for the patient – which makes it feel like this bit was written with a young child in mind. Also it should be recommending that services signpost patients to sources of non-clinical support like Beat. Also there is nothing on peer-support of any kind it seems.	This is covered in section 16.
	SG	Monitoring of implementation, consistency and quality is essential. This could be part of the Care Inspectorate &	The relevant teams within Healthcare Improvement Scotland will be made aware of the guideline's publication and make reference to SIGN's recommendations, and any clinical

		Healthcare Improvement Scotland assessment.	standards, when conducting inspections.
	AMc	Auditing current practice. Would it be useful to have a database or some centrally held information on people referred to services for treatment for an ED. When we have had FOI requests we can not provide this in our own area as people with ED are seen in different services. It could be helpful to monitor referrals/ diagnosis / therapies provided etc.	This is something for the national implementation group to consider and the suggestion will be passed on. The purpose of these audit points is to check if the guideline recommendations are being implemented.
	PC	Good pointers here to help think about service improvements.	Thank you.
	SMcC	Recommend that the guideline is utilised in the individual boards pathway for the care of eating disorders depending on the subject group	This is a general implementation issue and we would expect the guideline to inform health board pathways.
17.3	SGF	Important to audit uptake of services by BAME and minority population (collecting ethnicity data as recommended by MWC), LGBTQ+ and protected categories, Men with eating disorders - in order to analyse efficacy of implementation	The sentence, Collect specific data on the uptake of services by minority ethnic groups, men and people of different gender identities has been added.
	AG	Excellent as always with SIGN.	Thank you.
	JW	No issues	No action required.
	AR	Helpful statement of the current state of knowledge	No action required.
	AGe	No issues	No action required.
	HC	Research needs to be ongoing and appropriately funded.	Agree.
	SY	There are several evidence based papers which have been gathered by the British Association of Art Therapists to support the efficacy of art psychotherapy as a valuable intervention for people living with an eating disorder. I believe these are being submitted to this feedback/survey.	See response to FH comment on p10.
	EB	Research section – should cite IAMHRF study from November 2020 which gives best and most up to date data on lack of ED research funding –	Reference added.

		https://digitalscience.figshare.com/articles/report/The_Inequities_of_Mental_Health_Research_IAMHRF_/13055897	
	WW	In an area with limited funding for research, and appreciating that SIGN protocol exists for all medical guidelines at large, it is perhaps a pity that studies older than 10 years cannot be included - this is entirely appropriate to e.g. cardiology, perhaps less so eating disorders. e.g. older studies could have a downgraded evidence rating but still be included.	For practical reasons, given the number of key questions and size of the evidence review, the searches were capped at 10 years. The guideline group were aware that some therapies, such as family-based therapy, were established earlier, and this is noted in the evidence statement.
	SMcC	Would have been good to see some larger studies if available.	Larger studies were not available. The recommendations for further research call for large multicentre RCTs.
18.2	AH	It is reassuring that there is now more awareness of the high amount of people with an ED also are diagnosed retrospectively with ASD. More research is needed into this and how best to offer care and treatment to reduce relapse.	The call for research into the nature, management and effective treatment of autistic people who have eating disorders is listed as one of the recommendations for research.
	HB	Recommendations for research. First mention of 'autistic people' here (sic?). If that is indeed the case, should this group be mentioned earlier? Clear and compelling justification for need of guidelines.	The association between autism and eating disorders is highlighted in section 1.2.2.
	AG	Excellent as always with SIGN.	Thank you.
	JW	No issues	No action required.
	AR	Useful to have methods included	No action required.
	AGe	No issues	No action required.
	FH	Please include Art Therapy in the options of psychotherapy treatments.	See response to FH comment on p10.
	EB	Although not directly involved in the development of the Guideline, Beat ambassador has been which has been rewarding and had challenges. Beat is only providing comment on the points because of the evidence of the benefits they can provide to patients and carers.	Noted. Thank you for your comments.